Appendix B. State of Tennessee Department of Children's Services Coordination of Health Care Oversight and Coordination Plan

Coordination of Health Services Summary

Through interagency agreement and established processes, the Department of Children's Services (DCS) and the Tennessee Division of TennCare, the State of Tennessee's Medicaid program, and the selected Managed Care Organization, TennCare Select (TCS), collaborate to provide children in custody with primary physical and behavioral health services. DCS also partners with other state agencies including the Tennessee Department of Health, the Department of Education, and the Department of Intellectual and Developmental Disabilities Services to ensure care coordination and oversight. The following elements are inclusive of our Health Care Oversight and Coordination Plan.

DCS is supported by the Centers of Excellence, five centers that provide case consultation and specialty services for children in and at risk of state custody. DCS regional staff is supported by Child Health teams, which provide health support for children in custody. Children entering care are assigned immediate eligibility with TCS, a managed care company specifically serving custodial children.

Children that come into custody and are placed in a foster home receive an EPSDT screening at the Department of Health or designated provider within 72 hours. Recommendations of follow up services indicated by EPSDT screenings are sent to the DCS Child Health Nurse, who communicates the health service needs with the Family Service Worker (FSW). These service needs are tracked in the DCS child welfare tracking system (TFACTS), and access to the services is documented through the Health Confirmation and Follow Up form, completed by the health provider. The form provides information regarding additional follow up services, if needed.

In order to identify needs and strengths impacting placement for children age 5 and over, a Child and Adolescent Needs and Strengths assessment is completed which provides information regarding the behavioral health service needs of the child. This assessment informs the Child and Family Team the appropriate diagnosis and placement.

DCS incorporates the health and behavioral health needs of the child and family into the Functional Family Assessment (FFA) and Permanency Plan. The Child and Family Team meeting process encourages the communication of health needs, which is furthered by face to face visitation protocols which support ongoing communication regarding health needs. The FFA, among other assessment tools, is currently under review by an "Assessment Integration" workgroup.

Communication regarding health services is further enhanced by the informed consent practice of the department, supporting communication with the child's family regarding medications

and treatment. DCS has implemented specific training and monitoring to support Protection from Harm for children in care, including fostering positive behavior, medication administration and psychotropic medication monitoring.

Coordination of Health Services: Description

Collaboration of DCS and TennCare

Through interagency agreement and established processes, the Department of Children's Services and the Tennessee Division of TennCare collaborate to provide children in custody with primary physical and behavioral health services. DCS also partners with other state agencies including the Tennessee Department of Health, the Department of Education, and the Department of Intellectual and Developmental Disabilities Services to ensure care coordination and oversight.

TennCare (Medicaid) Eligibility

Immediate Eligibility, that is, presumed eligibility for TennCare upon entry into DCS custody is being revised significantly. Children covered by TennCare MCOs, UnitedHealthcare and Amerigroup, remain enrollees of the respective MCO until eligibility is determined newly for coverage by TennCare Select. Children who enter custody who are enrollees of BlueCare are automatically transitioned to TennCare Select as it is a product line of BlueCross/BlueShield.

The Medicaid eligibility process is being updated in compliance with Federal changes. The Bureau of TennCare will be more directly involved with eligibility determination when their system is completed.

TennCare Managed Care Companies

The Division of TennCare contracts with Managed Care Companies to provide TennCare services for TennCare enrollees. TennCare Select has developed a Best Practice Network (BPN) of providers to serve children in custody. It is composed of Primary Care Practitioners (PCPs), Dentists and Behavioral Health Providers[1] who have agreed to serve the health care needs of this unique population and to fulfill special roles and responsibilities associated with the management of children in state custody. The Best Practice Network Primary Care Practitioner (BPN PCP) administers basic health care and coordinates all physical and behavioral health care for the children assigned to him/her. The BPN PCP is responsible for providing a "medical home" for these children and maintaining all health records for the child, regardless of where the care is provided. All Providers are required to forward medical records to the BPN PCP so that a comprehensive medical record can be maintained. Dental services are provided statewide with a Dental managed care company subcontractor[2], and pharmacy services for all TennCare enrollees are provided through a statewide pharmacy benefits contract[3].

[1] The State of Tennessee TennCare program has implemented an integrated health care model; in the past the Behavioral Health plan was a separate managed care plan; the integrated plan for children in custody was effective 9/1/09.

[2] DentaQuest

[3] The PBM is Magellan

DCS, the Division of TennCare, and TCS meet on a regular basis to review and implement strategies to improve health care coordination to children in custody. This meeting is held quarterly, with follow ups as needed. Topics have included the care coordination of children with both medical and behavioral health needs, coordination of residential care for children at risk of custody, and specialized information for Foster Parents.

Centers of Excellence

DCS contracts with five Centers of Excellence (COEs) funded by TennCare to serve children in and at risk of state custody. However, in the very near future contracts with DCS will be terminated and the COEs will become contract providers of Blue Care. The Centers of Excellence and TCS remain committed to the COE's continuing to serve youth in and at risk of state's custody.

The COEs are strategically aligned with the State's academic medical centers and coordinated through the Department of Children's Services. The COEs provide consultation and evaluation for children who have complex behavioral and medical problems, and may provide direct services to children including psychiatric and psychological evaluations and medication management. Case consultation includes direct review and interaction on children in care with DCS staff.

Case consultation is a primary service provided by the COE for children both in and at risk of custody. Referrals are made by the DCS Regional Psychologist or community providers to the COE. Case consultation is completed by the COE interdisciplinary team, most often with DCS staff in attendance in person or by phone conferencing. Recommendations are made and the written consultation is compiled by one of the COE psychologists. Examples of recommendations include referrals for psychiatric evaluation with review of current medications and assessment for trauma/anxiety symptoms. Recommendations regarding most appropriate placement setting given the presenting behaviors and treatment needs are also frequently discussed.

The COE interdisciplinary team participates with DCS on *case reviews*, usually on a monthly basis, or more, depending on the COE. Prior to the case review, the COE assists in gathering records from the DCS worker and any other sources. This allows the COE clinicians to conduct a thorough review of past evaluations and gain an understanding of the youth's clinical picture prior to the case discussion. During the actual case review, the records and current case status are discussed, along with the presenting concern. The case review process enables the COE to provide recommendations to DCS on complex cases to identify whether further evaluation is needed, and to suggest appropriate treatment approaches. This often includes a discussion of diagnosis - which can be complex in our population. The COE guides the team in recommending further evaluation or consideration of alternate diagnoses if it appears that past therapies or evaluations do not appear to adequately capture the current diagnostic picture. Recommendations could also include management of symptoms in the home, obtaining therapy for the youth to focus on emotion regulation, or considering further testing to refine a

diagnosis for example. Recommendations may also focus on appropriate placement for our youth and can prevent youth from going to more restrictive settings than are necessary by helping the team understand the problem, the most effective treatment, and the best setting for that treatment to occur.

COEs and Best Practice development

For children with complicated medical problems, the COEs provide guidance to DCS regarding referrals and services to medical sub-specialties and hospital services to meet the child's needs. The COE consults with physicians serving children in foster care in the designated BPN (Best Practice Network).

The COEs have established learning collaboratives that educate providers about evidence-based approaches with a focus on services related to trauma. These practice models have included Trauma Focused Cognitive Behavioral Therapy (TFCBT) and Attachment Regulation Competency (ARC). For both TFCBT and ARC, providers and their management teams were required to apply and participate in order to ensure fidelity. Most recently the COEs have initiated a learning collaborative for Parent Child Psychotherapy, which is focused on positive infant mental health strategies and parental attachment and bonding. It supports the attention on infant mental health matters cited below.

By learning evidence-based practices that are new to them, members of our provider network refine not only their therapy skills, but their ability to conceptualize cases and develop diagnostic impressions regarding our youth in DCS custody. This helps decrease the probability of incorrect diagnoses and ensures that our youth have the best chance to receive appropriate and effective services, improving the likelihood for positive outcomes.

The COEs, two in particular, ETSU and UTHSC, were instrumental in the formation of the Association for Infant Mental Health in Tennessee (AIMHiTN), which had its first annual conference late summer, 2016. The Association members had met continuously under the leadership of the COEs for several years before formalizing the organization as a 501C3 in early spring 2017. AIMHiTN was awarded a grant by the *Building Strong Brains: Tennessee's ACEs Initiative* for FY17 to support the first Infant Court in the state. The Court, located in Davidson County, will continue to be funded and the model will be expanded by January 2019 to one Infant Court in each DCS Region.

The COEs have been recognized by the American Psychiatric Association as one of the top four innovative programs serving children in the United States. The COEs are located at Vanderbilt University Medical Center, University of Tennessee Health Sciences Center, East Tennessee State University Medical Center, University of Tennessee Knoxville, and Southeast Center of Excellence, Focus Psychiatric, Chattanooga.

DCS Health Coordination: Child Health Teams

Child Health Teams in the Tennessee child welfare program support FSWs, Foster Parents, and providers with recommendations and technical assistance for children and families.. The supports provided by the Child Health teams work collaboratively to reinforce permanency and safety.

Each of the 12 DCS regions has a Child Health team, which includes the following staff:

- Licensed doctoral level Psychologist or Master's level mental health practitioner
- Licensed Nurse
- Health Advocate Representative
- Services and Appeals Tracking Coordinator
- Educational Specialist

Adjunct Members:

- Independent Living Specialist
- Assessment Consultants

Child Health teams are responsible programmatically for the system of support for well-being services in their region. The Child Health Teams provide targeted technical assistance on specific cases from pre-custodial stages through transition to permanency. They serve as consultants on cases where the treatment, educational, or transition needs require specialized assistance to ensure children and youth are appropriately diagnosed and are placed in the most appropriate least restrictive living situation when possible.

Regional Psychologists also provide ongoing consultation. The clinician can assist in reviewing evaluations and help flag any diagnoses that may be inaccurate or no longer appropriate for a child, and guide the FSW to appropriate evaluation and treatment resources. The Regional Psychologist provides guidance regarding the most appropriate treatment or level of care for the child.

Child Health Triage

Initial Well Being Information and History

Well-being information is included in the initial assessment process for children entering care. As a child enters care, the initial contact, often the DCS Court Liaison or Child Protective Services Worker will gather pertinent health and educational information about the child from the family or caregiver. This information is captured on the Well Being Information and History form, and it is provided to the Child Health Team the next business day following a child's entry into care.

The Regional Child Health Nurse and Psychologist review the Well-Being Information and History form, and provide an initial review for the determination of immediate and non-immediate health needs. Policy (EPSDT 20.7) requires the DCS Regional Nurse to identify the need for immediate health care, including assessment for infectious and communicable diseases, and alert FSW's about immediate health needs identified. These recommendations

are provided in writing to the FSW. The Services and Appeals Tracking Coordinator (SAT) receives the recommendations and enters identified services into the electronic case record for tracking.

Regional Child Health Team members each review the paperwork for youth entering state's custody and get this information to the Family Service worker in the first 30 days. All disciplines of the Regional Child Health Team are included in this interdisciplinary review of the child and their presenting needs. The FSW and their supervisor receive all recommendations from the Child Health Team members in writing, and in some cases by phone as well. Action Steps are in turn assigned. For example, a school records request or a prescription refill might be issues identified as action steps. Unaddressed needs are tracked electronically in the case.

The Regional Psychologist's review of this initial medical and mental health information includes a review of diagnoses noted, reason for entering custody and circumstances, presenting behavior, and previous mental health services. Recommendations for mental health services may be made at that time, thus ensuring that mental health needs are appropriately addressed. By gathering mental health records and referring to mental health professionals to see our youth and make diagnoses, we increase the probability of arriving at accurate diagnoses and subsequently making the best possible placement decisions for our youth.

Concurrent with the above process, the Health Advocate Representative (or other regional designee) enrolls the child with TennCare Select for immediate eligibility. TCS assigns the child to a Primary Care Physician (PCP) that has been seeing the child when possible, is in the geographical area where the child will be placed, or at the request of DCS.

Child and Adolescent Needs and Strengths (CANS)

Within fifteen (15) days of a child's entry into care, the FSW completes the Child and Adolescent Needs and Strengths (CANS). The Child and Adolescent Needs and Strengths (CANS) is a family-focused, strengths-based, and culturally-competent standardized assessment completed in collaboration with children and families and other stakeholders in the case. The CANS is used to guide case planning through the identification of needs and strengths of each child and family served by DCS.

The CANS identifies the appropriate service needs and intensity level for each child and is used to guide service planning. The CANS service intensity level output guides the Child and Family Team in determining the appropriate service setting to meet the needs of the individual child and family. TheDCS protocol requires completion of the initial CANS within fifteen (15) business days of entry into care, and then no less than every six months (three months for children with a service intensity level of 4) or at intervals of major transition within the custody episode. Once the FSW has completed the CANS, it is reviewed clinically by the Vanderbilt University COE Assessment Consultant. Assessment Consultants clarify assessment information and ensure the accurate scoring of individual items.

As indicated earlier in this document, children in custody access medical and behavioral health services through the assigned TennCare Select; however, DCS is responsible for the contractors providing higher levels of care to children, including within Residential Treatment Centers (RTCs). TennCare contracts with DCS to provide residential services for children in custody[4]. DCS has a provider network to serve children through therapeutic foster care, residential treatment, and sub-acute services to ensure children are placed in the most appropriate living situation based on their medical and behavioral health needs.

Contracting for mental health services directly allows DCS the ability to monitor these providers serving children with complex needs. The dual Foster Care/Residential Treatment system assures individualized, flexible planning for children with complex needs with flexibility to meet their needs in less restrictive settings. See monitoring graph.

Further supports are provided to the CFTM in the placement determination process through the Child Health teams. Children With Special Healthcare Needs are reviewed by the Regional Child Health Nurse, and children referred to higher level (sub-acute) residential behavioral health services are reviewed by the Regional Child Health Psychologist.

EPSDT

Policy 20.7 Early Periodic Screening Diagnosis and Treatment directs FSWs to obtain an EPSDT screening or a health screening within 72 hours of custody. If the child has a 72 hour health screening, they will receive an EPSDT screening within the first 30 days of custody. Results of the EPSDT screening or health screening are sent to the Regional Health Nurses who, in turn, make recommendations for follow-up care. Those recommendations are provided to the child's placement caregiver and the FSW, who assist in scheduling the recommended follow-up services.

Initial and annual EPSDT screenings are provided by the state Health Departments (available in each county) or designated providers who are knowledgeable about foster care and Medicaid requirements of EPSDT screening components. The purpose of these visits is to identify physical, mental, or developmental problems and risks as early as possible and to link children to needed diagnostic and treatment services.

Under Federal EPSDT regulations, screening visits consist of a comprehensive health and developmental history, an unclothed physical exam, vision and hearing screenings, appropriate immunizations, laboratory tests, and health education. The Pediatric Symptom Checklist (PSC) and the Parents' Evaluation of Developmental Status (PEDS) are also part of the EPSDT screening.

[4] When children are not in custody, residential services are provided through the Managed Care Company (BHO).

A summary sheet indicating the completed components and findings of the screening is provided by the Health Department or designated provider to the child's assigned PCP (primary care provider) with a copy to the Regional Child Health Nurse.

Immunizations are not typically provided during the EPSD&T due to lack of current records being available. In instances when a component is not completed due to illness related to the screening element, children are referred for services relating to screening components that were not completed (i.e. child had ear infection; referral is made and then hearing screening was completed).

The Regional Child Health Services and Appeals Tracking Coordinator (SAT) enters the completed EPSDT and the follow up recommendations into TFACTS. If there are follow up services resulting from the EPSDT, the Regional Services and Appeals Tracking Coordinator (SAT) will request an appointment date from the FSW. A report can be generated from TFACTS with incomplete appointments or incomplete follow up. All health services that the child receives are available on the client health services summary in TFACTS.

Ongoing EPSDT screening

All children in custody receive an annual EPSDT screening conducted by the local Health Department in accordance with the American Academy of Pediatrics periodicity schedule. Children under age 3 receive an EPSDT screening more frequently according the periodicity schedule. Youth remaining in extension of foster care after age 18 continue to receive EPSDT screenings until they exit care at age 21.

Reports are provided to regional DCS programs monthly of all children who have a screening that will be needed in the next 60 days, as well as a report of children who have/have not met their annual screening.

Coordination of care between DCS and TCS

In addition to the efforts, TCS contacts the DCS FSW when gaps in care are identified and are available to assist with establishing appointments and with referral information. These include gaps related to EPSDT, ADHD medication monitoring, and immunizations for 2 and 13 year-olds. TCS Behavioral Management contacts the DCS FSW when a child has entered custody and provides information regarding assistance available for referrals to case management at TCS, to assist with behavioral health needs for all children.

For children with care coordination needs or a child with more significant health care requests may be referred to Medical Case Management at TCS. Case Managers follow the case management process and an individualized plan of care is created for each member. Interventions may include assistance with obtaining ancillary services such as durable medical equipment/supplies, Home Health Services, and Physical Therapy or help with discharge planning from an Inpatient Facility. Case Management also assists members who need out of state coordination of care. Caregivers/resource parents are contacted either

telephonically or by a face to face visit. Collaboration occurs as needed with member's assigned DCS contacts to ensure the member's care is taken care of.

DSC FSWs and foster parents can call the dedicated customer service line any time for assistance from TCS. Staff taking these calls is dedicated to assisting children in foster care, FSWs and foster parents.

TCS issues general health information to Central Office personnel which are in turn shared with DCS Health Advocate Representatives and foster parents.

The dedicated Case Manager for DCS participates in inter/multidisciplinary rounds, CFTMs and case discussions as applicable to the member care and treatment as necessary on complex cases, provide updates and details of current member situation.

Several personnel from various departments attend the DCS foster parent conference held annually. Information regarding medical and behavioral health care is provided, notebooks for tracking medical care are given away, and training on various topics from feedings, navigating the health care system, to caring for a traumatized child are provided by TCS staff and Medical Directors.

Dental Care

All children/youth entering care age one (1) or older receive an initial EPSDT dental examination by a dentist within thirty (30) days of entering care unless the child/youth has received a dental exam within the last six months. Children under one (1) year can be seen by a dentist if an oral health assessment is needed or if an oral health problem is suspected per DCS Policy 20.12

Dental examinations often indicate the need for additional dental treatment and require follow-up appointments. Dental treatment may include diagnostic services, preventive services, restorative procedures, extractions, and specialty care as medically necessary. If a child has a cavity, toothache, or other dental related problem, an appointment is be made to assess that particular problem as needed. Following the initial assessment, youth receive a dental exam and cleaning every six (6) months or as recommended by the dentist.

Compliance for EPSDT Medical screening has been documented at 90% or above for the last 5 years. Dental EPSDT compliance is currently at 92%.

Tracking all Health Services: Health Confirmation and Follow Up

In addition to tracking EPSDT, when a child receives any type of health service (except for the EPSDT screening), the Health Services Confirmation and Follow up form (CS-0689), is given to the provider with a request that the form be completed or the information provided.

The Health Confirmation and Follow up form allows a provider to:

- Communicate brief information about the health visit and findings
- Provide information regarding any follow up services identified and

- Communicate with DCS, TennCare, the DCS provider, and the DCS Foster Parent.

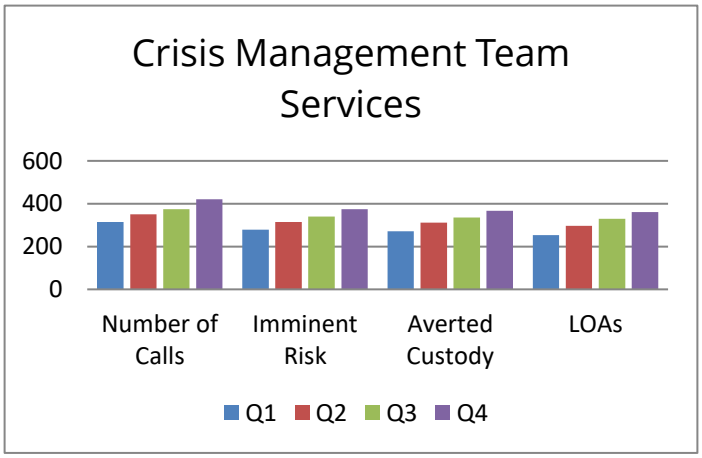
The information on completed health services, as well as needed services, is entered by the Services and Appeals Tracking (SAT) Coordinator into TFACTS. The information can then be printed into a document known as the health summary in TFACTS and provided to persons caring for the child.

The cycle of identifying health services and confirming a child's access to health services is continuous and is aided through this process of entry into the child welfare tracking system. Reports support this process. DCS has adopted a protocol for how reports will be used at the regional level to identify children for whom screenings or follow up services have not been documented (Attachment A). By the fall of 2018, a significant build of TFACTS will have been deployed, making this tracking process more precise and easier to follow for each youth.

In 2013 the John B Lawsuit, in which DCS was named, was vacated as the court found the state to be in substantial compliance with EPSDT standards. DCS is maintaining those standards and is still audited for that compliance. In January, 2017, the state was also released from requirements of the *Grier* Lawsuit that established appeal rights of all TennCare recipients whose services were denied, diminished or delayed.

Crisis Management Team

The Crisis Management Team (CMT) manages a TennCare-funded process which increases the likelihood that children at risk of custody will be treated in the community without coming into custody for services. The team, a part of the DCS Child Health Team, has been highly successful in averting custody for hundreds of children as depicted here for calendar year 2017. Sources of referral to the CMT include the courts, Department of Children's Services, and parents. The CMT works with the child's assigned MCO to identify resources for appropriate care.



Trauma Assessment

DCS becomes involved with families when there is a risk to a child's safety and care while recognizing that children are impacted when separation from their family occurs. Having this knowledge DCS works in conjunction with the Office of Permanence and with support of external partners to accurately assess trauma in children. The broadest and most general mental health screening is a component of the EPSDT which occurs within 30 days of a child/youth entering custody. This would potentially identify symptoms which could be

attributable to trauma that a child/youth experienced. If the EPSDT screening identifies mental health symptoms then a more thorough mental health assessment is arranged.

The most specific screening process, the Child and Adolescent Needs and Strengths (CANS) Assessment, is conducted on children/youth 5 and older within 5 days of entering custody. A specific "trauma module" is embedded within the Tennessee version of the CANS. When the "trauma experiences" item of the CANS is scored as warranting further exploration then the trauma module is used to assess the child/youth more fully. This involves: types of trauma that the child/youth has experienced (e.g., sexual abuse, physical abuse, neglect, natural disaster, witness to family violence, etc.), symptoms experienced (e.g., numbing, dissociation, avoidance, re-experience, etc.), and if the trauma is sexual abuse further details (e.g., frequency, duration, force, etc.). The CANS highlights strengths and needs of the child/youth and family which will assist in determining appropriate therapeutic approaches to take with care. There is also the capacity to analyze the aggregated trauma information gathered through the CANS to assist with systems issues. For example, this information combined with information of geographic resource availability of trauma treatment enables DCS to identify potential geographic gaps in services.

As with any child, trauma or mental health conditions may not be disclosed or realized until later points in time. When this occurs a referral for evaluation and treatment through contract and/or community mental health providers is made.

Technical Assistance by Child Health Teams

Child Health Teams are active in the life of a case while children and families receive care through DCS. FSWs may consult with these professionals and specialists on an ongoing basis, and they often participate in the Child and Family Team Meeting (CFTM).

The specialized roles of child health include the following:

Support of Placement determinations

Regional Psychologists are responsible for consulting on any case in which a youth is being considered for a Residential Treatment Center (RTC). This gives clinicians the opportunity to determine why the request is being made, and add any clinical recommendations they may have. For example, the Psychologist may advise the team that the youth's diagnoses do not alone justify the need for an RTC and ask the team to gather more information about current behaviors and symptoms prior to making this type of placement. This provides a check and balance which prevents youth from going to an RTC based on diagnosis alone or without clinical review for medical necessity. In addition to this, The Assessment Consultants support the placement determination process and The Regional Nurse approves placements of Youth With Special Healthcare Needs.

Access to Child Health Services

- The Regional Psychologist and Regional Nurse provide FSWs, Foster Parents and other DCS staff with explanation and understanding of psychological testing, medical tests, and other health matters.
- The Health Advocate Representative assists FSWs, Foster Parents, and other DCS staff with access to TennCare services, and if there are access barriers will address these or file TennCare appeals as needed.
- The Health Advocate Representative serves as a liaison to identify and support transition to adult Long-Term Supports and Services (LTSS) and/or mental health services.
- The Independent Living Specialists support Independent Living planning and implementation, and manage post-custody cases.
- The Educational Consultant attends IEP meetings and Child and Family Team Meetings, interacts and engages local education agencies, conducts training for schools and staff, and supports the educational passport process.
- Transition to adult services is very successful as it is closely monitored for timely moves.
- Any denials, delay or termination of medical/ behavioral services are resolved and the monitoring process is reported to the federal court monthly.
- Children in residential treatment services through DCS are monitored by the TennCare advocates for appropriateness of services.

Coordinating Special Populations

Children Birth to Three

Children entering care under the age of 3 are referred to the Tennessee Early Intervention Services (TEIS) program for evaluation in five developmental domains—cognitive, physical, communicative, social/emotional, or adaptive skills—and implementation of any identified service needs. The Regional Educational Specialist of the Child Health Team responds to any concerns regarding this referral process and service.

Children with Special Health Care Needs

The Children with Special Health Care Needs Foster Care program provides recruitment, training, and support services to foster parents to meet the needs of children/youth who are appropriate for family-based care but require a higher level of medical support, intervention, and case coordination. Some of these foster parents are also trained to manage behavioral and emotional disorders in addition to the training required to meet the medical needs of this population.

The Regional Child Health Nurses review these cases and make the determination to place the child in a designated foster home with caregivers who have received specialized training in the care of that child. The nurses provide ongoing oversight for these children and coordinates with TennCare Select for managed care case coordination when appropriate.

Temporary Safety Placement for Children with Special Health Care Needs

Should a child enter custody in need of life-sustaining medications, treatments, or specialized medical equipment such as tube feedings, oxygen therapy, suctioning, tracheostomy care, and breathing with the aid of a ventilator and specialized foster care is not available TCS will arrange for these children to be placed in a hospital until a placement can be identified and the caregiver can receive training related to specific medical needs of the child. Safety placements are coordinated by the Regional Child Health Nurses and TCS.

Coordination for Psychiatric Hospitalization

TCS and DCS coordinate regarding inpatient psychiatric hospital stays for children in custody. TCS case management works to ensure that DCS Child Health is aware of the hospitalization, working as a liaison between the hospital and DCS to facilitate medication consents for children in the hospital, and to collaborate regarding discharge planning.

TCS also has a dedicated case manager to assist DCS with crisis situations. This case manager establishes prompt and timely contacts with Mobile Crisis, providers, community agencies and internal health programs for members that are awaiting hospitalization for acute care, while waiting in emergency rooms or other settings. This case manager may also contact the member or their guardian.

Integrated Care

DCS and TennCare Select coordinate cases for children that require receipt of concurrent medical and behavioral health services. A case coordinator is assigned at TennCare Select to work actively with the DCS Regional Child Health Nurse and other DCS staff.

Child Health partners with TCS on two monthly Collaborative Rounds conference calls designed to enhance our partnership in an effort to serve youth in custody as effectively as possible. This is a venue to discuss complex cases with a larger team that includes DCS foster care staff, the Child Health Unit staff, medical and behavioral health staff (psychiatrists, psychologists, pediatrician, nurses, and social workers) and TCS, giving us the best chance possible of successful outcomes.

Transition to specialized TennCare services

DCS works with the designated Managed Care Organization (MCO) to ensure youth in custody with mental health needs receive adult mental health TennCare services, when appropriate. Likewise, youth with intellectual and developmental disabilities are identified and referred to the TennCare-funded CHOICES or Employment and Community First (ECF) CHOICES Program which may offer the type and level of support that will sustain the youth in the community after the youth reaches adulthood and is no longer involved with the Department. The transition to LTSS is based on the youth's eligibility and the availability of open, funded waiver slots. Technical support is provided through the Office of Child Welfare Reform.

Juvenile Justice Youth

A Psychologist from Child Health partners with the Office of Juvenile Justice to provide a broad range of consultation services for Juvenile Justice youth placed at one of the two Youth Development Centers run by DCS. The Psychologist provides case consultations on individual cases, works with the Youth Development Center staff to support a therapeutic treatment milieu, and provides monitoring and support for the contracted mental health providers that serve the Youth Development Centers. The Psychologist is also involved in program evaluation work in collaboration with Vanderbilt Peabody Research Institute, conducting Standardized Program Evaluation Protocol (SPEP) work for the Youth Development Centers.

Communicating about Health Needs

Child and Family Teams

Treatment for trauma, neglect, physical health and behavioral health is contiguous with the path to permanency. The well-being of children in care is included in the Child and Family Team Meeting. Results of the EPSDT are incorporated into the Permanency Plan, and identified service needs are included in the Permanency Plan.

DCS Providers and Foster Homes

As part of the initial placement process, DCS providers or Foster Homes receive the authorization for routine health services, Insurance or TennCare information, medications and medication information, and health information. (Policy 16.46). The CFTM addresses well-being needs and engages all team members. (Policy 31.7). The CFTM protocol requires the CFTM to assess the concerns, issues and underlying needs of the family/child. The plan is based on assessments made through the Family Functional Assessment, CANS, SDM, EPSDT, mental health assessment or other evaluations.

For ongoing communication regarding health needs, the visitation protocol (adjunct to Policy 16.38, Face to Face visitation) requires engagement regarding health issues and encourages parents to participate in all of their child's healthcare appointments. The protocol indicates that visits are an opportunity to ensure communication and coordination of health services. The health summary, available in the TFACTS Health icon, is to be printed and provided to the facility or home. Responsibility for arrangements of identified services is to be discussed.

Foster Parents are supported by a Foster Parent Support Worker, the Foster Parent Advocacy Program, and may contact trained foster parent peers from the mentoring program for any concerns, including health care for children in their care. Information on health services is provided during initial training for Foster Parents, Parents as Tender Healers (PATH), and a fall conference is held. Foster parents may contact the Well Being team members directly regarding health concerns for children in their care. The Health Advocate Representative communicates important TCS information to the Foster Parents in their region through meetings and training opportunities.

TennCare eligibility information when exiting care

Information about the continuation of TennCare (Medicaid) benefits for children exiting care to permanency through adoption or reunification, and young adults transitioning to post custody is provided as part of the transition Child and Family Team Meeting (CFTM).

A flyer *How to Keep TennCare for your child* is provided to the family and youth. Changes in the eligibility system will allow youth leaving care to transition their Medicaid benefits seamlessly. The extension of benefits is being communicated and supported for those youth.

Informed Consent

Every individual has the right to receive information regarding prescribed tests or treatments, including risks and benefits of taking the tests or treatments and risks/benefits of not taking the tests or treatments. In order for children in custody to receive appropriate health services, DCS facilitates the informed consent process by involving the parent, guardian, or older youth in the consent process, or by providing consent as appropriate.

Parents are engaged in health care decision making through the Child and Family Team meeting process. Parents are initially asked to provide consent for routine health services for minors, unless parental rights have been terminated. The parent should be engaged to consent for all routine health services, emergency services, surgeries, and medications. In the event the parent is unavailable to provide consent for routine services, the FSW, Foster Parent, private provider caseworker, and the designated Youth Development Center staff are authorized by DCS to give consent for routine medical care. In the event the parent is unable to provide consent, (*or parental right have been terminated)*, for surgeries and psychotropic medications, the DCS Regional Child Health Nurse provides consent. DCS Policy 20.24 describes this process.

Medication Administration

DCS has implemented policies regarding medication administration (Policy 20.15).
The Medication administration policy includes requirements for training, assistance with self-administration, refusal of medication, transport of medication, medication documentation, storage, and disposal.

DCS requires tracking of medication errors by DCS providers for children in state custody. Medication errors are entered into TFACTS and notifications are provided to Regional Child Health Nurses for review.

"Medication Administration for Foster Parents" is a training workshop that provides Foster Parents the knowledge to safely and effectively administer medications to children in their care. The DCS training division provides this training for our foster parents in a four-hour introductory class and in a two-hour refresher class that is taken every 2 years.

Protection from Harm
Foster Parent training

DCS firmly believes in a positive approach to parenting in which any type of corporal punishment is strongly prohibited. DCS equips its foster parents to work with youth with a history of trauma with a course entitled "Trauma Informed Parenting Strategies." Foster parents take a three-hour online course on de-escalation techniques to help not only de-escalate disruptive behavior, but to help prevent disruptive behavior. This course looks at the important task of working with a youth after an incident and teaches coping skills and techniques that allow youth to regulate their own behaviors in the future. This course also covers self-care techniques for foster parents to use, in an acknowledgement that it is difficult to support children who have experienced trauma and that children can often trigger emotions in parents that make it difficult to parent calmly and reduce the risk of disrupting the child/youth's less restrictive placement.

DCS monitors the use of restrictive behavior management techniques such as seclusion and restraint, through the Incident Reporting System contained within TFACTS. Providers enter incidents, which are then reviewed in detail by the Regional Psychologists, who in turn responds and follow up on any concerning items. Incident reports are also reviewed in aggregate form, through site visits, and in annual reviews.

Psychotropic Medication Administration and Monitoring

Department policy prohibits the use of psychotropic medication as a method of discipline or control of a child. The combined policies and procedures of the Department and TennCare related to the administration of psychotropic medications are well-designed to ensure compliance with this prohibition.

TennCare requires that any prescription for any psychotropic medications must be supported by an appropriate DSM diagnosis and a treatment plan with measurable outcomes. In addition, prescriptions for two medications in the same class or for doses outside of recommended ranges cannot be filled without prior approval.

Department policy further requires review by a Regional Nurse and approval from a Psychiatrist or Psychiatric Nurse Practitioner at the Vanderbilt Center of Excellence (COE) for:

- youth five years old and under;
- two medications in the same class;
- four or more medications; and
- any dose outside of recommended ranges.

These reviews are handled by the Center of Excellence as follows:

- A specially constituted "red flag team" run by Psychiatric Mental Health Nurse Practitioners, and supported by a child psychiatrist, has assumed responsibility for review, approval and support for DCS Nurses in responding to specific "red flag" cases.

- The COE Nurse Practitioners extensively evaluate the proposed medication regimens via consultation with the DCS Regional Nurses looking at the child's current symptoms, current and past medications, medical history and any relevant objective medical information including vital signs, lab values, EKGs and EEGs.
- The COE Nurse Practitioners (NP) use evidence base practice to make decisions and specific recommendations around the use of psychotropic medications in children.
- The COE NPs maintain availability for consultation to DCS Nurses and prescribers regarding questions or concerns around any child's psychiatric treatment plan.
- The COE NPs have engaged with prescribers to ensure safety and efficacy in the context of red flag approved medical regimens.
- The COE NPs have created and distributed a comprehensive list of FDA approved maximum dosage parameters for psychotropic medication to the DCS Nurses for quick reference.

In addition to these measures, the Department is partnering with the Vanderbilt Center of Excellence, TCS, Division of TennCare, and prescribing physicians from the community to develop a peer-to-peer messenger model. A statistical modeling process has been developed by the biostatistics team at Vanderbilt in which providers who are outliers in prescribing psychotropic medications may be identified. The model corrects for the CANS score of the youth and several other variables, to ensure that the type of population the prescriber is treating is taken into account in predicting how many red flag prescriptions we expect. This number is then compared to the actual number of red flag prescriptions written by that provider. The statistical model has been developed, vetted by prescribing physicians in the workgroup, revised, and further vetted. The next step will be to develop a peer-to-peer messenger model in which one physician in a medical group would approach another physician in the same group, and present some basic facts about the prescribing habits of their peer. Peer reviewed literature supports this type of model as a method of shaping physician behavior in a desirable direction.

Youth in level 3 and 4 residential facilities are reviewed monthly for medical necessity by a Utilization Review (UR) Team that includes Regional Psychologists. Issues of medication use are reviewed in the context of the overall treatment plan. Any uses of medication that do not conform to DCS policy or that are otherwise concerning are expected to be brought to the attention of the Vanderbilt Team.

Psychotropic Medication Policy Training Curriculum is required for all Contract Providers and DCS Staff to complete during Pre-Service Training as well as every two (2) years. This curriculum is available from DCS.

Ensuring Quality of Services

As noted in the 2019 TN APSR Report (p. 82-83), DCS has a strong foundational administrative structure for Performance and Quality Improvement (PQI) across the State of Tennessee. This includes several bodies which help ensure that youth receive appropriate services from providers. Experts from Child Health are integrated into each of these, helping to ensure that there is a clinical voice at the table.

Provider Quality Team

The Provider Quality Team (PQT) consists of a multidisciplinary team of experts who are responsible for overseeing the monitoring of all contract provider agencies to ensure facilities are meeting standards and expectations set forth by DCS. Moreover, PQT discusses concerns that may impact the provider agency or Youth Development Center's ability to provide quality services. The team develops action steps to include recommendations for the particular staff member or the provider agency identified in the concerns. The recommendations may include training, face-to-face meetings and implementing Quality Improvement Plans. When concerns or issues warrant an in-depth review or analysis, PQT serves as a response team to; collect data, make recommendations, and provide technical assistance, as needed.

Foster Home Quality Team

The Foster Home Quality Team (FHQT) works to ensure that foster care placements and providers have the ability to provide safety and promote the well-being of children following an SIU investigation or concern. The Division of Foster Home Quality is responsible for placing foster homes on Suspended Admissions due to being investigated by SIU and notifying the provider agency and local DCS staff of the suspended admissions. The suspended admissions are initiated to prevent additional placements being added to the home during the investigation period. Once the Division of Foster Home Quality is notified of the outcome of the investigation, the suspended admissions are either lifted or the home is reviewed by the Foster Home Quality Team. Trends of allegations and number of investigations for each foster home are tracked and reviewed during the Foster Home Quality Team meeting to ensure appropriate decisions are made. The Foster Home Quality Team meets weekly and consists of individuals from the following DCS divisions: Safety, Health, Risk Management, Foster Care, Policy, Program Accountability Review, Training, Utilization Review, Placement, Network Development, and Foster Parent Advocacy. This partnership will help improve the provider barriers identified during the CFSR process.

Contract Monitoring Quality Team

The Contract Monitoring Quality Team (CMQT) monitors, evaluates, and works to enhance the quality and effectiveness of contracts and services purchased from other provider organizations or independent contractors. CMQT focuses on all contracts and Delegated Purchase Authority providers both custodial and non-custodial that fall outside the scope of Tennessee DCS residential/performance based contracts. CMQT meets monthly to review and discuss regional and central office referrals and concerns identified by contract monitors. CMQT may contact the provider to facilitate partnership and collaboration in seeking a

resolution. Quality Improvement Plans may be initiated as necessary to resolve the concerns. The Contract Monitoring Quality Team consists of individuals from the following DCS divisions: Foster Care, Program Accountability Review, Health, Fiscal, Continuous Quality Improvement, Legal, Juvenile Justice, and Risk Management. This process will help improve the provider barriers identified in the Child and Family Service Review.

Services provided by external partners

TCS has been very responsive each time DCS has identified a TennCare Select provider who may demonstrate concerning practice in some way. Should DCS staff or foster parents have concerns about a TCS provider, they may call the customer service number on the back of their TCS card. Quality Management at TCS will investigate the complaint and take action if appropriate.

Collaboration with Pediatricians

Behaviorally Effective Healthcare in Pediatrics (BEHIP)

BEHIP is a collaborative training project between BlueCare and the Tennessee Chapter of the American Academy of Pediatrics (TNAAP). The goal of BEHIP is to support pediatric primary care practitioners (PCPs) by: a) Providing tools and strategies for effective and efficient screening, assessment and management of patients with behavioral health issues and substance use disorders, b) Informing PCPs of regional behavioral health resources, c) Emphasizing principles of systems based practice to behavioral health disorders in primary care setting, d) Assisting PCPs in developing office-based protocols to improve communication and collaboration with the behavioral health system of care.

The activities that further this mission include a) face-to-face and online Pediatrician education involving increasing confidence and competency in behavioral health screening, communication with patients and families, understanding treatments, referral process and networking. b) Six guidance videos on anxiety, inattention and impulsivity, depression, disruptive behavior and aggression, social/emotional guidance for children birth to age 5 and SUD, and c) Additional education on trauma-informed care, Adverse Childhood Events, navigating the Department of Children's Services, basic psychopharmacology. The program is currently in its third evolution, which includes identifying and training providers, building relationships between providers and their Centers of Excellence for Children in state custody, and creating a team learning collaborative. DCS clinicians have been invited to be part of this process and the youth with whom DCS interface clearly benefit from this in that more and more PCP's are becoming versed in navigating behavioral health issues and interfacing with DCS.