

2020-2024 Health Care Oversight and Coordination Plan

Introduction

Kentucky has been moving forward on the oversight and coordination of both physical and behavioral health for children in out of home care (OOHC) over the past seven years. Most major efforts formally initiated after the ACF conference “Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care” in August of 2012.

The Department for Community Based Services (the department) is the umbrella agency for the public child welfare department and in 2012 did not employ a physician or psychiatrist. The previous physician for the department had taken another position. This resulted in very limited access to a physician for routine or event related medical issues. Additionally, around the same time of the departure of the physician, Kentucky implemented managed care for Medicaid through managed care organizations (MCOs) on a statewide basis. This resulted in the department being in need of an enhanced clinical consultation process for both physical and behavioral health for frontline staff.

The department has struggled over the past seven years to recruit and retain nurses, behavioral health professionals, and a physician. Kentucky faces some unique challenges recruiting these types of professionals that include competition with other governmental (Veteran’s Administration) and non-governmental agencies (MCOs, etc.); salary schedules that are not competitive with the federal government, nor the private sector; flat or frozen salaries; and uncertainty about the state’s employee pension system.

In 2014, there were renewed efforts that began with an enhanced relationship with both the Department for Medicaid Services (DMS) and the University of Louisville (UofL), which resulted in the first iteration of a statewide system to assess the use of psychotropic medications in the foster care population. Additionally, UofL was interested in developing a new partnership to provide support in the realm of physical health.

In 2015 there was a gubernatorial election in Kentucky that brought in the current executive management team in the Cabinet for Health and Family Services (cabinet). The Governor has made reform and improvement of the state’s child welfare system one of his signature policy initiatives. This policy brought renewed efforts within the cabinet to work across departments in order to achieve this policy goal.

The department began substantial changes in 2016 by bringing a licensed clinician into the Commissioner’s Office that had experience collaborating with DMS. This allowed for more clinical input at the executive level of the department, as well as within the Division of Protection and Permanency (division). This resulted in a partnership with DMS allowing a board-certified child & adolescent psychiatrist to be hired and stationed within the department as a medical director for the first time in approximately eight years.

In 2016 within the division, efforts to recruit and retain both nurses and behavioral health professionals was both renewed and intensified, and two behavioral health clinicians on boarded into the division. On October 1, 2018, the department underwent a major reorganization to establish the Clinical Services Branch (CSB) within the division.

The CSB provides physical health and behavioral health consultation and oversight for the department. The CSB, in conjunction with the medical director, the Office of the Commissioner, and the Division of Service Regions (DSR) implements health care oversight at the state and individual case level. The CSB has an authorized staff compliment of a branch manager, three behavioral health professionals, and two nurses. Currently, the branch only has one vacancy; a nurse position. This is significant, as it marks the first onboarding of a nurse into the division in over six years.

The medical director, in partnership with the cabinet's Office of Data Analytics, has developed an application that utilizes Medicaid and pharmacy claims data to create dashboards, which can show utilization of psychotropic medications for all children in foster care. The dashboard can be queried and configured related to various demographic filters to provide information on the utilization of medications at a case level. This information is used to identify and monitor overall trends, as well as isolate individual medication patterns appropriate for case review. The program allows clinical staff at the department to evaluate any child in OOHC for psychotropic medication usage, which facilitates opportunities to reach out to prescribers, agencies, and other health care providers related to use.

The renewed inter-departmental partnership initiative has resulted in a significantly enhanced partnership between the department and DMS. This partnership lead to significant input from the child welfare perspective into new initiatives at DMS and with the MCOs. Additionally, Kentucky will be undergoing a major update to the managed care Medicaid initiative by releasing a new request for proposals and it is anticipated that this process will result in many enhancements for children involved with the child welfare system and possibly a single MCO to serve this population.

Initial and Follow-Up Health Screenings

Kentucky has codified standards of practice (SOP) on initial health screenings upon entry to into OOHC. However, it is well known that all children need regularly scheduled screening and assessment to monitor their development.

One of the challenges that Kentucky faces related to follow-up and regularly scheduled medical care for children in OOHC is that a portion of the population is not stable in their placements and often move between different levels of care. These moves in levels of care are often, if not always, accompanied by geographic moves as well.

Kentucky is proposing to address follow up care via a multi-pronged approach that will include the following:

1. Using the knowledge and expertise of the medical director, nurses within the division, and MCOs to develop and implement standards and best practices for screening and follow up. It is anticipated that some of these standards will be related to healthcare effectiveness information data and information sets or HEDIS measures. The medical director, in partnership with the cabinet's Office of Data Analytics is developing a second dashboard application that utilizes Medicaid and pharmacy claims data to monitor many healthcare quality measures, including rates of mental health care, well-child visits, dental care, and vision checks.
2. Explore the assignment and implementation of a medical home for children in OOHC. The majority of children in OOHC are relatively stable in placement and geography. This allows for implementation of a medical home, which is anticipated to enhance care via continuity of providers and services.

3. Kentucky will undertake efforts to stabilize placements for children through the use of behavioral health consults, physical health consults, and new initiatives with the residential and foster care partners.

Monitoring and Treating Health Needs

Kentucky is proposing to utilize existing SOP related to initial screening, medically complex foster care, possible assignment to medical homes, and consults with CSB nurses and behavioral health staff as the primary method to monitor healthcare issues and emotional trauma, including that trauma associated with the child's removal from their home.

Additionally, over the past six years, Kentucky has implemented a universal screening and assessment process for all children coming into state custody. Through ACF grant funding Kentucky implemented Screening and Assessment For Enhanced Service Provision to All Children Every day (SAFESPACE) in partnership with UofL, which uses a Kentucky specific version of the Child and Adolescent Needs And Strengths (CANS) instrument to screen all children entering OOHC for trauma issues and other behavioral health needs. Children that screen in based upon the use of the CANS are then referred on for a behavioral health assessment based upon information provided from the CANS.

Additionally, as part of the SAFESPACE project, Kentucky is sustaining the project through the use of a data system operated by a non-governmental agency titled KidNet which tracks all of the items in the CANS and also uses data from Kentucky's CCWIS. This allows for both individual case level and aggregate data around a variety of behavioral health data that was previously unavailable. Additionally, Kentucky is in an extended partnership with UofL to manage and analyze data to help the department move toward data-driven decisions and policy in the realm of behavioral health.

Updating and Sharing Medical Information for Children in Care

Kentucky has been using the Medical Passport as the primary means for collecting, updating, and sharing relevant medical information. This is a three ring binder, which is used to collect, store, and make available health care information for children in OOHC. In the past, numbers of children in care, geographic issues, a mixed public private system, technology issues, and cost factors have prevented Kentucky from moving forward on an update to this long outdated process.

Kentucky is expected to move to model where there will be a single MCO for all children in foster care. If this idea is implemented successfully, it offers a multitude of opportunities to use the data management and analysis capacity of a private health insurance company to partner with the department to update this process. If implemented, this would mark the first time that all of the health data on children in care is housed within the same MCO.

Oversight and Protocols for Prescription Medicines

Kentucky is proposing to use a multi-pronged approach to the monitoring for appropriate use of medicines including psychotropic medications.

1. Utilize the dashboard application to identify questionable or problematic use of psychotropic medications in the foster care population. This application can screen by many variables including, age, sex, class of psychotropic medication, and time frames. The application has the

ability to monitor overall trends to drive policy decisions, as well as identify specific cases of concerning psychotropic medication practices for case review and education. These consult calls include department frontline staff, MCO representatives, and providers to review the complex histories and problems which lead to polypharmacy and offers an extensive review and reformulation of the treatment plan. It is only a matter of scale to expand this application of a similar application to include all prescription medicines as opposed to a focus on psychotropic medications. In addition, the Children's Review Program (CRP), which supports the department in monitoring safety and well-being of children in OOHC, monitors and provides monthly reports on children treated with multiple psychotropic medications.

2. Enhancing partnerships with MCOs or a single MCO for children in foster care. An enhanced partnership with the MCOs will allow the department to maximize the benefit of a private health care company's data collection, management, and analysis capacity. MCOs routinely monitor for similar issues via fidelity to their formularies, as well as to expenditures and other issues. There will be opportunities in this new era of managed care to examine medication usage. Through consultation, education, and peer review, best practice guidelines for the use of medications can be introduced into the care of children in OOHC.
3. Utilize the consultation capacity within the division to reach out to partners and prescribers to consult on specific cases. Identification via MCO or dashboard application of specific cases will allow for consults which will include the medical director, nurses, and behavioral health staff.
4. The Service Regional Clinical Associates (SRCAs) are the leading clinical personnel in each region who address clinical issues, as well as train and educate personnel in their regions. The medical director has monthly conferences with the SRCAs to discuss and educate on best practice guidelines for the use of medications in children in OOHC.
5. The process of informed consent for the use of psychotropic medications continues via established SOP. The SRCAs are receiving education and training on the components of effective informed consent including shared decision-making to provide to the field workers in each region.

Consulting with Physicians and Other Professional

Consultation and administration of the medically complex foster care program are two of the main goals of the CSB. The CSB, through nurses on staff, review referred cases to determine whether the child meets the criteria for the medically complex designation. This designation affects the rate paid for care, as well as the development of a health care plan for the child that is monitored on an ongoing basis by the nurses.

Consultation on health and well-being from the CSB includes a mix of behavioral health staff, nurses, and the department's medical director. These consults most frequently occur by conference call, however, may also include record review, attendance at treatment events, attendance at treatment team meetings, and direct meeting with providers. One of the main roles of the CSB and medical director involves direct communications with physicians and other specialty providers to monitor and clarify care of medically and psychiatrically complex children. Additionally, the CSB is located approximately seventy miles from UofL and approximately forty miles from The University of Kentucky (UK). Both of these state universities have medical schools and the department has numerous formal

and informal relationships with the hospitals and various medical programs and staff at both UK and UofL.

Procedures and Protocols to Ensure Appropriate Diagnoses

Anecdotal observations by CSB staff reveal that there are trends in diagnosis for the population of children with intensive behavioral health needs. These observations reveal that these children tend to exhibit externalizing behavior styles and tend to be assigned a cluster of diagnoses that tend to progress over time if the child's needs are not met appropriately. This diagnostic cluster tends to show up in the preschool or elementary school ages as attention-deficit/hyperactivity disorders (ADHD). As the child ages and behavioral health needs are not met, the diagnoses begin to reflect more severe externalizing behaviors such as oppositional defiant disorder (ODD) and disruptive mood dysregulation disorder (DMDD). Finally, throughout adolescence the more severe diagnoses of bipolar disorders and conduct disorder are a possibility in a child with unmet needs. This diagnostic pattern may or may not also include post-traumatic stress disorder (PTSD). This diagnostic pattern appears to be overly focused on externalizing behaviors and if that is the case, is likely off the mark for children that internalize their experiences. Anecdotally, the single common factor that is most undiagnosed is the role that trauma plays in these cases.

Currently, there are approximately 175-200 children in OOHC on any given day that are designated as medically complex. Within this population is a wide variety of conditions which vary from children being maintained on ventilators, to children with cancer, hematological disorders, and more common conditions such as diabetes or seizure disorders. The two most common conditions that result in medically complex designation are seizure disorders and diabetes.

Additionally, there are more cases of children in care with rare or unusual conditions. These include chromosomal conditions, genetic issues, metabolic conditions, and other rare syndromes. It is believed that the rapidly advancing field of genetics and genetic assessment and testing are uncovering conditions that, until recently, went undiagnosed. At this point, it is unclear what the implications for this particular issue are, as time and technology advance.

Kentucky is proposing a multi-pronged approach to monitor diagnoses and how children in state custody are placed related to diagnoses.

1. Build on the existing models of consult, case review, and assessment to ensure, in the cases known or referred to the CSB or the medical director that diagnoses are accurate, that the child is linked to the most appropriate accessible forms of treatment, and monitoring or follow up as necessary.
2. The dashboard application can track the rates of psychiatric diagnoses listed on Medicaid claims for children in foster care.
3. Utilize the dashboard application to review for questionable or inappropriate medication usage. While questionable medication usage on its own may not signal a questionable diagnosis, in some cases exploration of medication usage can also have a positive effect related to monitoring an individual child's diagnoses.
4. Enhance established relationships with MCOs related to diagnostics. Kentucky is now over seven years into implementation of managed care for Medicaid. Approximately 75% of the children that enter OOHC are already members of Medicaid MCOs. The implication is that for a

significant portion of the population of children under the age of ten that will enter OOHC in the coming years will have a medical history that will be accessible and able to be interpreted through encounter, diagnostic, and pharmacy data from the MCOs. This dynamic will be strengthened should Kentucky implement a single MCO for children in OOHC.

5. Kentucky intends to be an early implementation state for the Families First Prevention Services Act (FFPSA) and plans to implement in October of 2019. One of the major pieces for implementation is surrounding enhanced procedures and oversight related to the use of congregate (residential) care and the development of the qualified residential treatment program (QRTP). QRTP qualifications will represent an enhancement over what is typically provided in residential care currently. Additionally, the requirements of independent assessments and judicial oversight of treatment in the QRTP setting should help to prevent inappropriate placement and offer diagnostic clarity in a set of complex cases.

Transition Planning Development Process and Health Care Needs

In Kentucky, youth that age out of foster care are eligible for health insurance through Medicaid until the age of 26. In cases where it is recognized that a youth may age out of state custody, there are designated efforts undertaken at the case level to ensure that these youth are advised of the benefits of opting for an extended commitment for education or vocation means. This process includes transitional meetings and completion of a transition planning document. In cases when the youth states that they are not interested in extending their commitment, transition planning typically begins around age 16 with a formal transition meeting and plan development age 17. Youth in Kentucky can extend their commitment prior to the age of 18 or after exiting youth can reinstate their commitment prior to reaching 19 years of age. In cases where a youth chooses to extend their commitment, there are formal transitional planning meetings at ages of 19 and 20.

These formal discharge planning meetings include discussions of and implementation of the following:

- Health insurance and Medicaid options;
- Health care Power of Attorney or Health Care Proxy and facilitated executions;
- Obtaining necessary documents (birth certificate, Social Security Card, etc.); and
- Variety of other issues related to transition planning.