Cabinet for Health and Family Services
Department for Community Based Services

2025-2029 Health Care Oversight and Coordination Plan

Contents

Introduction

Kentucky has made significant progress in the oversight and coordination of both physical and behavioral health for children in out-of-home care (OOHC) over the past seven years. The department has struggled over the past several 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 such as managed care organizations (MCOs). However, over the past four years, the department has reviewed salary schedules and worked successfully to make major salary adjustments which has helped with retention and will likely help with recruiting in the future.

The department continues to collaborate with the Department for Medicaid Services (DMS) and the University of Louisville (UofL), in the operation of a statewide system to assess the use of psychotropic medications in the foster care population and support regarding the physical health of children in OOHC.

In partnership with DMS, the department employees a board-certified child and adolescent psychiatrist as medical director.

The Division of Protection and Permanency's (DPP) Clinical Services Branch (CSB) provides physical health and behavioral health consultation and oversight for the department. 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. CSB has an authorized staff compliment of a branch manager, three behavioral health professionals, two nurses, and two social services specialist positions.

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 and isolate individual medication patterns appropriate for case review. The program allows clinical staff within 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.

Kentucky in partnership with Aetna Better Health of Kentucky, established a single MCO for children in foster care. The Supporting Kentucky Youth (SKY) program provides many enhanced benefits and services and fine tunes practice to meet the unique challenges of children in state custody.

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.

Kentucky's plan to address follow-up care is a multi-pronged approach that will include the following:

1. Use 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 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. Most 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. Undertake efforts to stabilize placements for children using behavioral health consults, physical health consults, and new initiatives with the residential and foster care partners.
4. Analyze and consider implementation of the recommendations from a CSB nurse who completed a study of these health screenings as part of a Doctor of Nursing program.

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.

Kentucky has implemented a universal screening and assessment process for all children coming into state custody. Children who screen in for trauma issues and other behavioral health needs are referred for a behavioral health assessment which uses a Kentucky specific version of the Child and Adolescent Needs and Strengths (CANS) assessment. Upon assessment, children are referred for services based on the outcome of their individual assessment.

CANS assessments are entered into the Qualo system, managed through a contract with Advanced Metrics, which tracks items in the CANS and interfaces with 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 behavioral health realm.

During the 2025-2029 Child and Family Services Plan (CFSP), Kentucky will complete universal implementation of screening and assessment for children involved with the department. This implementation will include both children in the custody or parents, family member, and those in custody of the state. This expansion of screening and assessment has been made possible through enhanced collaborations with the state Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) and UofL.

Updating and Sharing Medical Information for Children in Care

Kentucky has used 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 continues to explore methods moving to an enhanced system to replace or augment the medical passport. With implementation of SKY, Kentucky can explore 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. Since implementation of SKY, all health data for children in care is housed within the same MCO. As Kentucky continues to collaborate with SKY, this data set will grow and become more beneficial for analysis and program development.

Oversight and Protocols for Prescription Medicines

Kentucky plans to use a multi-pronged approach to continue monitoring the appropriate use of medications, including psychotropic medications.

1. Utilize the dashboard to identify questionable or problematic use of psychotropic medications in the foster care population. This dashboard can screen by many variables including, age, sex, class of psychotropic medication, and time frames and can 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 dashboard 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. Enhance 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 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 via established SOP. The SRCAs receive 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 CSB. 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 via a virtual media platform (Teams or Zoom), however, may also include record review, attendance at treatment events, attendance at treatment team meetings, and direct meetings 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 in close physical proximity to UofL and the University of Kentucky (UK). Both 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 trends in diagnosis for the population of children with intensive behavioral health needs. These observations reveal that these children exhibit externalizing behavior styles and are assigned a cluster of diagnoses that 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 sever 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) and appears to be overly focused on externalizing behaviors. If that is the case, it 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 220 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 most common condition that results in medically complex designation are seizure disorders.

Additionally, there are more cases of children in care with rare or unusual conditions. As access to complex genetic, metabolic, and chromosomal testing has increased, more of these cases are being

identified. These include chromosomal conditions, genetic issues, metabolic conditions, and other rare syndromes. It is unclear what the implications for this issue are as time and technology advance.

Kentucky's plan is 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 CSB or the medical director that diagnoses are accurate, the child is linked to the most appropriate accessible forms of treatment and monitoring or follow-up as necessary.
2. Continue to monitor the dashboard to 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. Approximately 75% of the children who 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 10 who 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.
5. Continue to collaborate with the Aetna SKY program to further enhance and fine tune services and programming for children in state custody.
6. Monitor and review QRTP independent assessments and judicial oversight of treatment in the QRTP setting to assess whether this prevents inappropriate placement and offers diagnostic clarity in a set of complex cases.

Transition Planning Development Process and Health Care Needs

In Kentucky, youth who age out of foster care are eligible for Medicaid through Aetna SKY 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 extended commitment for education or vocation means. This process includes transitional meetings and completion of a transition planning. In cases when the youth states 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. 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.