



# North Carolina Child Welfare 2020 – 2024 Health Care Oversight and Coordination Plan



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**  
Division of Social Services

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## Frequently Used Acronyms

AACAP	American Academy of Child and Adolescent Psychiatry
AAP	American Academy of Pediatrics
APSR	Annual Progress and Services Report
CCA	Comprehensive Clinical Assessment
CCNC	Community Care of North Carolina (Care coordination for children age 5-18)
CFSP	Child and Family Services Plan
CFSR	Child and Family Services Review
CMARC	Care Management for At-Risk Children (Care coordination for birth to five) - formerly CC4C
DSS	Division of Social Services (within the Department of Health and Human Services)
EPSDT	Early Periodic Screening Diagnostic Treatment
FHNC	Fostering Health NC
HOCP	Health[care] Oversight and Coordination Plan
NCIR	North Carolina Immunization Registry
OSRI	Onsite Review Instrument
PCP	Primary Care Physician
SAYSO	Strong Able Youth Speaking Out

## Frequently Used Terms

*Transition Age Youth* (TAY) refers to youth between the ages of 14 and 18.

*Young Adult* refers to adults between the ages of 18 and 26.

*Resource Parents* refers to foster, adoptive, therapeutic foster care parents, or kinship caregivers.

*Child/youth* is most often used at the request of young people in foster care.

## Section I: Overview

### Introduction



The Health Care Oversight and Coordination Plan (HOCP) affords states the opportunity to integrate numerous federal health requirements for children/youth in foster care into a comprehensive plan. The HOCP provides education to stakeholders and a framework to galvanize those serving the foster care population to achieve core outcomes by 2024. The activities contained within this plan are designed to improve individual child/youth health outcomes and strengthen the child welfare system's ability to achieve

safety, permanency, and well-being for all children. The plan is developed in collaboration with stakeholders and helps states to develop plans that use federal funding effectively and secures positive outcomes for the children and families it serves.

North Carolina collaborates with key stakeholders across the state to integrate all aspects of health programming and align efforts into comprehensive health care plan. Stakeholders include DSS, North Carolina Pediatric Society (NC Peds), NC Medicaid, Division of Public Health (DPH), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), pediatricians, psychiatrists, pharmacists, county departments of social services, private child placing agencies, and families who have received child welfare services.

North Carolina's vision is that all children in the state will have a healthy start and develop their full potential in safe and nurturing families, schools, and communities. For the most vulnerable children – those who have experienced or are at risk of experiencing child abuse and/or neglect – services must be in place to strengthen families and prevent child maltreatment and unnecessary family separation. When child welfare is involved with children, youth, and families, health programming is guided by the following principles:<sup>1</sup>

- Assure the safety of children/youth and promote their healthy development and permanency
- Respect families as partners in identifying and meeting child/youth and family needs
- Help prepare youth emancipating from the foster care system for self-sufficiency and independent living
- Deliver timely, individualized, and coordinated services that are principally accessible in the home or community
- Meet the comprehensive health and well-being needs of children, youth, and families
- Mobilize all existing state and community resources to help families solve the problems which compromised their functioning and well-being

North Carolina currently has approximately 11,500 children/youth in foster care. As of February 2019, 39% were under the age of 5, 31% were ages 6-12, 23% were age 13-17, and 7% were age 18-20. Approximately 52% were placed in family foster homes or with relatives, 7% in group homes, 9% were placed in medically necessary treatment facilities (therapeutic family foster care, therapeutic group care, psychiatric residential facilities, etc.), 7% in juvenile justice placements, and 10% were placed in other living arrangements. Children/youth in foster care also incur greater health care costs compared

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<sup>1</sup> Based on the Code of Federal Regulation (CFR) that govern child welfare programming  
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to their age-matched peers enrolled in the state’s Medicaid program. Despite higher health-related expenditures, children/youth in DSS custody often continue to demonstrate poor health and well-being outcomes.

**What is the Connection Between the HOCP and the CFSR?**

The Child and Family Services Review (CFSR) provides the Children’s Bureau a structured way to help states identify strengths and areas needing improvement within their agencies and programs.<sup>2</sup> Ultimately, the goal of the CFSR is to help states improve child welfare services and achieve substantial conformity in seven Safety, Permanency, and Well-Being Outcomes and seven Systemic Factors.<sup>3</sup> A child/youth’s safety, permanency, and well-being outcomes are all interconnected. For example, when a family is unable to manage a child’s physical health issues, the child may not be safe. If a foster family is unable to manage a child’s behavioral issues, it may affect the child’s placement stability or permanency. For the purposes of the oversight by the Children’s Bureau, health outcomes live under Well-Being, specifically CFSR Well-Being 3.

*Well-Being Outcome 3*

Items under Well-Being Outcome 3 address whether children/youth receive adequate services to meet their physical/dental health (item 17) needs and their mental/behavioral health (item 18) needs. The state pulls a random sample of cases to review, and the score of these items serve as a benchmark for the state’s performance on health programming within child welfare services.

The table below captures North Carolina’s recent performance regarding Well-Being Outcome 3 using the federally recognized quality assurance tool – the Onsite Review Instrument (OSRI). While the individual items are themselves important, in order for the CFSR Well-Being Outcome 3 to be found in substantial conformity, both item 17 and item 18 on each child need to be adequately addressed. Percent of cases reviewed using the OSRI that were found to be in substantial compliance.

	2017 Results (n=213)	8/18 – 1/19 (n=213)	CFSR Goal
<b>Well-Being Outcome 3</b> <i>Both Item 17 and Item 18 were in substantial conformity</i>	68.00%	69.31%	95%
Item 17: Physical/Dental	77.65%	72.29%	95%
Item 18: Mental/Behavioral	76.39%	82.19%	95%

*What has changed since the last HOCP?*

Since the 2015-2019 HOCP, North Carolina’s landscape has changed for both health care services and child welfare services. North Carolina’s health care system is transforming from a *Fee for Service* Medicaid program to a primarily *Managed Care* system beginning in 2019. North Carolina opted to delay transitioning the foster and adoptive population to Medicaid Managed Care in order to develop a *Specialty Plan* that addressed the unique needs of this population. Children/youth with high behavioral health needs will be served by the *Tailored Plan* beginning in 2021. For more information on Medicaid Transformation, please visit <https://www.ncdhhs.gov/assistance/medicaid-transformation>.

North Carolina’s child welfare system is undertaking a major transition from a centrally-supervised to a regionally-supervised system. Child welfare reform efforts also include a change from a primarily

<sup>2</sup> For general overview of child welfare programing, please view a 20-minute video at [www.fosteringnc.org/cw101](http://www.fosteringnc.org/cw101).

<sup>3</sup> All seven outcomes and seven systemic factors can be referenced at <https://tinyurl.com/CFSR-Items>  
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paper-based record system to an electronic child welfare case management system. This is in addition to preparing for juvenile justice reform and Family First Prevention Services Act programming. All these landscape changes impact health programming for the child welfare population.

#### *Assessing the Effectiveness of the 2015-2019 HOCP*

While the previous Child and Family Services Plan successfully documented North Carolina's health programming activities and educating stakeholders, it was not leveraged as an action plan for health programming across the state. Furthermore, it was not utilized as a tool to support North Carolina in achieving substantial conformity on the CFSR Well-Being 3 outcome and the relevant CFSR Systemic Factors. Given this marginal effectiveness, North Carolina sought to develop this 2020-2024 HOCP that galvanizes stakeholders and aligns networks of health services to achieve positive outcomes for children/youth in foster care through aspirational goals and a stronger emphasis on federal regulations and CFSR outcomes.

#### *Four Key Lessons Learned from the 2015-2019 HOCP*

**Lesson 1 – Goals Should Be Aspirational, Defined, and Measurable.** The 2015-2019 HOCP outlined in narrative form how North Carolina was meeting each of the federal requirements and included a highly aspirational vision for strengthening health services to children/youth. It did not contain Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goals that could be reported in the CFSP's APSR. The current plan maintains the aspirational nature of the previous plan, while making it more practical for use in the child welfare community.

*Incorporating Lesson 1 moving forward.* This 2020-2024 HOCP targets specific strategies that North Carolina needs to achieve to improve health care for children in foster care. Progress toward the SMART goals (expressed as commitments/targets) will be included in the APSR along with any substantial changes to health programming.

**Lesson 2 – System Reform Efforts Have a Tremendous Impact on Health Programming.** Health programming is deeply impacted by broader system reform efforts and challenges. For example, North Carolina has undergone several major reforms that impact the child welfare population. These include, but are not limited to, Medicaid Transformation (and earlier Mental Health Reform efforts), Raise the Age Juvenile Justice Reform, and the implementation of an electronic case management system for child welfare – North Carolina Families Accessing Services through Technology (NC FAST). Additional system changes will come with the Family First Prevention Services Act.

*Incorporating Lesson 2 moving forward.* When broader system efforts are deployed, the foster care population requires proactive leadership and collaborative stakeholder engagement to mitigate issues (intended and unintended consequences). The 2020-2024 HOCP programming will include leadership representation from NC Medicaid, Community Care of North Carolina (CCNC), and Care Management for At-Risk Children (CMARC) on all teaming structures. Additionally, the Strategic Plan of the CFSP addresses the need for Child Welfare both state and county leadership to be included in the development of the Specialty Plan that will be a part of Medicaid Transformation.

**Lesson 3 – Efforts to Improve the Health of Children in Foster Care Require a System and Child Specific Approach and They Must be Aligned.** North Carolina’s previous HOCP addressed child specific health by impacting the practice of child welfare workers and resource parents. It also focused on building a health care system specific to the needs of children in foster care. While the previous plan addressed both, work remains to ensure there is clarity regarding how the workforce interfaces with the health care system.

*Incorporating Lesson 3 moving forward.* Seamless, person-centered care is critical to the long-term well-being of children in foster care. Coordination of care across physical and behavioral health providers, child welfare agencies, NC Medicaid, CCNC, and CMARC must be streamlined. Further, health care information must be shared in a coordinated way among entities and providers to ensure the healthcare needs of children in foster care are being met in a timely manner. The 2020-2024 HOCP includes specific targets and strategies to align a network of services for all children and youth in foster care.

**Lesson 4 – Efforts Should Be Anchored to the Appropriate Governing Entity.** While the 2015-2019 HOCP was developed in collaboration with the medical community, it was not operationalized in a way that informed child welfare practice or leveraged to improve child welfare CFR outcomes. The FHNC contract was administered by the NCDHHS Office of Rural Health, for example, rather than by DSS. This unintentionally created barriers to maximizing programming potential and aligning efforts with the expectations of federal child welfare partners.

*Incorporating Lesson 4 moving forward.* In 2017, the FHNC contract moved under the administration of the DSS and a deliverable was added to better support and align the HOCP and FHNC work. By anchoring the HOCP in FHNC programming, will help to align health programming across systems. Moving forward, FHNC will play a vital role in supporting DSS’ efforts to ensure that children and youth in foster care are linked and remain linked to a medical home by providing ongoing assistance and implementation support to county child welfare agencies and stakeholders who are currently implementing the foster care Medical Home Model.

#### *Program Improvement Plan Connection*

North Carolina included two key activities in its 2017-2018 Program Improvement Plan (PIP) that impacted health programming.

First, a goal was included to strengthen the cross-system service provision, specifically to strengthen the collaboration between county departments of social services and Local Managing Entities/Managed Care Organizations (LME/MCOs). This body of work, referred to as *Bridging Local Systems*, developed structures to improve collaboration and hold each other accountable for achieving accessible, quality, and timely behavioral health services for child welfare-involved children/youth. Improvements were made;<sup>4</sup> however, this body of work will require ongoing collaboration and attention. As FHNC programming further defines its workgroup composition and structure through charters, FHNC will strive to have LME/MCO representation on all teaming structures.

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<sup>4</sup> <http://nciom.org/bridging-local-systems-strategies-for-behavioral-health-and-social-services-collaboration-2/>

Second, the improvements and changes to the child welfare manual include information about health programming, specifically around standards regarding the frequency of visits. DSS, in partnership with FHNC, will continue to strengthen the state's policies and procedures regarding health care needs of children/youth in foster care. DSS will also work to build capacity within the child welfare workforce by creating an infrastructure that supports resources, culture and partnership needs and provides technical assistance to state/regional staff to support counties in securing positive health outcomes for children/youth.

### *What Challenges Did We Face During the Last Five Years?*

North Carolina faced three key challenges to health programming over the last five years.

First, North Carolina continues to experience inconsistency regarding the availability of health services across the state. In particular, the impact on rural communities is significant given that some families and child welfare workers must travel great distances to access health professionals.

Second, North Carolina experienced high child welfare staff turnover rates which impacted health programming at the county-level (approximately 32% annually). Turnover challenges the agency's ability to ensure the continuity of health programming over time. Therefore, plans to develop materials to support the transfer of knowledge and streamline the onboarding of new staff relative to the transfer of information, including health programming, should be created.

Third, North Carolina experienced several significant reform efforts over the last five years mentioned earlier. These efforts offer an opportunity for North Carolina to strengthen health programming for the foster/adoptive population. However, they also present a challenge to securing positive health outcomes during transition.



## Section II. Health Programming Laws and Regulations

The Children's Bureau requires states to document in its Health Care Oversight and Coordination Plan its compliance with each of the health requirements outlined in the Social Security Act [422(b)(15)(A)]. The following outlines how North Carolina's child welfare system addresses each of those federal requirements.

### **Coordination and Collaboration with Health Care Experts for the Development of the HOCP**

The North Carolina Division of Social Services (DSS) contracts with NC Peds, which is the North Carolina Chapter of the American Academy of Pediatrics (AAP), to ensure there is coordination with pediatricians and other experts in health care, as well as with experts in, and recipients of, child welfare services. NC Peds is responsible for administering the Fostering Health NC (FHNC) Program, a program specifically designed to improve the health of North Carolina children in foster care. Guided by its State Advisory Team, FHNC ensures there is substantial, ongoing, and meaningful coordination and collaboration among key stakeholders at the state and local level to provide trauma-informed care for this population. This team includes collaboration between North Carolina Division of Health Benefits (NC Medicaid), pediatricians, psychiatrists, general practitioners, dentists, child welfare experts, recipients of child welfare services, care managers, pharmacists, and other specialists in the ongoing oversight and coordination of the health care needs of this vulnerable population.

The FHNC State Advisory Team or its workgroups meet monthly to ensure North Carolina has ongoing consultation with its stakeholders and is coordinating with NC Medicaid to improve systemic healthcare issues (*CFSR Systemic Factor Agency Responsiveness to Community*). The FHNC State Advisory Team reviews the Health Care Oversight and Coordination Plan on an ongoing basis to identify barriers to implementation and ensure children and youth served by the foster care system receive adequate services to meet their physical, mental/behavioral and dental health needs.

NC Medicaid and DSS are committed to providing care management/care coordination for this vulnerable population. Community Care of North Carolina (CCNC) is currently the lead agency responsible for providing this critical function. CCNC is a public-private partnership of physicians, nurses, pharmacists, hospitals, health departments, social service agencies, and other community organizations. These professionals work together to provide cooperative, coordinated care through the Medical Home model (see [Requirement 4 – Ensuring Continuity of Health Services and Establishing Medical Homes](#) for more information on the Medical Home model). This approach matches each child/youth in foster care with a primary care provider who leads a health care team that addresses the patient's health needs.

Another key partner in the coordination of health services to children in foster care is Care Management for At Risk Children (CMARC) [formerly Care Coordination for Children (CC4C)]. CMARC is a partnership between CCNC, the North Carolina Division of Public Health, and NC Medicaid. CMARC performs similarly to CCNC but is focused on serving children from birth to 5

years who meet certain risk criteria. Entry into foster care is one such risk criterion, given the child's exposure to toxic stress. As part of the Fostering Health NC model, county DSS staff work closely to refer all children under the age of 5 to CMARC for care management services.

### **Requirement 1 – Schedule for Initial and Follow-Up Health Screenings**

In a system abundant with transitions and psychosocial stressors (such as changes in visitation and separation of siblings) youth in foster care indicate a need for closer monitoring. The required schedule for children/youth in foster care includes an initial health screening visit within 7 days of placement, a comprehensive health visit within 30 days of placement, and well-visits at least every year (more frequently for children under age two). NC Child Welfare policy requires children to be seen more frequently if directed by the medical provider. Because services are provided through a Medical Home model, children receive consistent care from medical professionals who are aware of their history and thus able to assess and provide for their medical needs. NC Child Welfare Policy notes both the minimum required medical care as well as the enhanced AAP recommended care.

#### **Initial Health Screening**

A brief health screening visit (approximately 15 minutes) occurs within seven days of a child's initial placement into foster care. At the initial health screening visit, the medical provider addresses acute or chronic health conditions/issues, growth parameters, medications provided/prescribed, immunizations, allergies, communicable diseases, and other urgent home or school concerns. The medical provider then establishes a treatment plan including follow-up appointments, needed labs/testing, and immunizations, as well as how the health needs should be monitored by the child welfare worker and caregiver/placement provider. Additionally, the medical provider makes appropriate referrals for specialists or documents any other services needed to address any identified gaps in care, including documenting the need for a medication review if appropriate.

The medical provider completes the Initial Visit for Infants/Children/Youth in DSS Custody Form (DSS-5206) and it is shared with the child welfare worker and resource family (foster parent, kinship care parent, or pre-adoptive parent). This form was adapted using the AAP's Healthy Foster Care America Health Summary Form with input from medical providers.

#### **30-Day Comprehensive Health Visit**

Prior to the 30-Day Comprehensive Health Visit, the child welfare worker completes the Health History Form (DSS-5207) which is sent to the medical provider (see [Requirement 3 - Updating and Sharing Medical Information](#) section below) no later than one week prior to the Comprehensive Visit.

Children/youth in foster care should have a comprehensive health evaluation within 30 days of placement into foster care to address their acute and preventive health needs. The medical provider completes the 30-day Comprehensive Visit for Infants/Children/Youth in DSS Custody (DSS-5208) form during this extensive medical visit (approximately 45-90 minutes). The medical

provider will follow-up on any health needs identified in the Initial Visit and explore the child's medical history or presenting concerns including, but not limited to:

- Vision Screening
- Hearing Screening
- Oral Health Needs
- Developmental Needs
- Social-Emotional Needs
- Mental Health Needs
- Substance Use
- Educational Concerns
- Family and Social History
- Allergies
- Medication Oversight and Monitoring

The medical provider develops a plan, which includes medically necessary recommendations for follow-up treatment or intervention and provides referrals to specialists to meet those needs. These can include such services as early intervention, dental care, medication review and evaluation, or dietary assessment. The provider establishes a treatment plan, including how the health needs will be monitored, and gives instructions to the child welfare worker, resource parent and/or school staff. Prior to the end of the visit, a subsequent well-visit appointment is scheduled. The completed DSS-5208 is then shared with the appropriate stakeholders.

In addition to the screenings named above, DSS policy requires evaluation of multiple needs within 30 days of entry into foster care. These are:

- A mental health evaluation, with ongoing monitoring and assessment as needed;
- A developmental health evaluation if under the age of 6, with ongoing monitoring and assessment as needed;
- An educational evaluation if over the age of 5; and
- A dental evaluation (NOTE: if known, this should be based on the last time the child had a dental evaluation).

If, after assessing the child, one or more of the above evaluations are determined to be not needed, documentation as to why must be provided.

Follow-up Health Screenings and Updating Medical Information – The frequency of follow-up health screenings, often referred to as Well-Visits, occur according to the age of the child/youth. The medical provider will follow-up on any health needs identified during the initial visit, 30-day comprehensive visit, or previous well-visits. Additional care and attention will be paid to addressing needs and experiences germane to the foster care population. These might include: a discussion of how visitation with birth families can affect health and well-being, whether a placement disruption has occurred and its potential impact on health and hygiene, and/or separate conversations with youth and resource parents about strengths and needs

relevant to the placement itself. Any updates related to the presenting concerns listed above in the “30-Day Comprehensive Health Visit” section will be made in the health record and treatment plan and necessary referrals will be made. The medical provider completes the Well-Visit for Infants/Children/Youth in DSS Custody Form (DSS-5209), which was adapted from the AAP’s Healthy Foster Care America Health Summary Form.

If the child/youth is prescribed a psychotropic medication, collaboration occurs between the primary care provider, other prescribers, and other members of the child/youth’s care team. The medical provider updates the treatment plan including any recommendations for follow-up services and how the health needs will be monitored. Referrals to specialists are made as needed. The provider gives instructions to the child welfare worker and resource parent. Prior to the end of the visit, the next well-visit is scheduled. The completed DSS-5209 is then provided to the resource parent, child welfare worker, and the CCNC/CMARC Care Manager.

The following summarizes the health summary forms and some key considerations to support positive outcomes for children/youth.

<b>Form Title</b>	<b>Form</b>	<b>Completed by</b>	<b>Key Reminders</b>
Initial Screening Visit	DSS-5206	Primary Care Provider	Along with the visit summary, helps to accurately assess for acute health needs in a timely manner and assists in initiating the development of the initial treatment plan.
Health History Form	DSS-5207	Child Welfare Worker	Documents historical health information known by county child welfare agencies at time of custody. Includes diagnoses, medications taken, birth history and educational needs. Shared with the PCP to tailor the 30-day comprehensive visit to meet the specific needs of each individual child/youth.
30-day Comprehensive	DSS-5208	Primary Care Provider	Identifies needed service referrals and gaps in care based on information disclosed during the initial screening visit or provided on the health history form. Specific focus is placed on discussing medications and completing developmental and social-emotional screenings in order to make subsequent referrals to specialists as needed.
Well-Visit (Annual + Complex Follow-up Visit)	DSS-5209	Primary Care Provider	Reviews changes in medical needs, behavior, etc. since previous appointments to update the treatment plan.

In addition to CFSR Quality Assurance Reviews, North Carolina’s Program Monitoring Team tracks well-being data regarding children in foster care including: completion of required forms; initial 7-day screening; 30-day comprehensive visit; annual well-visit; twice annual dental checkups; participation of placement provider in medical appointments; giving both parents the opportunity to participate in medical appointments; medical information shared with appropriate parties; and medical continuity for the child. The following table represents health care outcomes for children in foster care from January – December 2018:

<b>Requirement</b>	<b>Number of Cases Reviewed</b>	<b>% of Cases in Compliance</b>
Initial Screening Visit	95	71.6%
30-day Comprehensive	91	51.6%
Annual Well-Visit	78	85.9%
Twice Annual Dental Checkups	67	68.7%

In addition, out of 92 cases reviewed during this time period, medical continuity for the child was found in 70.7% of the cases.

**Requirement 2 – Structural Supports for Meeting Physical and Mental Health Needs (Including Addressing Trauma Associated with Maltreatment and Removal from Home)**

As mentioned above, global health needs are identified through the initial screening visits and through subsequent well-visits with the medical provider. Medical providers across North Carolina are exposed to the research on toxic stress and adverse childhood experiences (ACES). In addition to the work of the medical community, North Carolina has strong trauma programming across various disciplines. This work supports the identification and treatment of health needs associated with the emotional trauma of a child/youth’s maltreatment and removal from home, as well as the prevention of misdiagnosis. More information on trauma programming is outlined under [Requirement 7](#).

Equal to the systems in place providing education to medical providers on the impact of trauma on child well-being are the child welfare specific policies and procedures that establish timeframes for intervention according to the specific needs of the child/youth. NC Child Welfare Manual includes policies that ensure case specific monitoring and treatment of identified physical, emotional, and trauma treatment needs. In acknowledgement of the ways in which removal from the home can be traumatizing for a child/youth, child welfare staff are required to complete a face-to-face contact with the child/youth in their foster home within seven days of initial placement into foster care and within seven days of any subsequent placement changes. Child welfare workers are instructed to discuss any health needs and/or observations at this visit. The initial 7-day visit also serves as an ideal time for foster parents to be provided a copy of the completed DSS-5206 Health Summary Form-Initial. This form is a standardized way of documenting the medical provider’s observations of the child’s health, follow up referrals made, and conditions that require additional monitoring, and serves as a baseline indication of the child’s health. The provider can also use this to document the timeframe in which they want the child to return for their next appointment. NC Child Welfare

Policy guides workers in assessing and monitoring physical health needs of children/youth in foster care through the use of the periodic visits and associated forms mentioned above. It also provides child welfare workers with a contextual understanding of the effect removal has on children and their role in mitigating the trauma that can exist as a result of it. The North Carolina Child Welfare Manual for Permanency Planning states the following:

“During the early stages of placement, the child should have close contact with the county child welfare worker, until a relationship with the placement provider is established. Children removed from their homes need special attention and frequent contacts at the time of placement in county child welfare services agency custody, as well as any time a move from one placement to another is made.”

During monthly contacts, child welfare workers monitor factors that directly affect health, such as prescribed medications, medical and mental health appointments, and changes in affect. Workers also gather information on factors that indirectly impact health and well-being, such as relationships and changes that occur within the placement, contact with birth family members, educational needs and extracurricular activities. To ensure consistency in content of visits, the North Carolina Monthly Permanency Planning Contact Record (DSS-5295) is a required documentation tool. This form provides a framework to monitor changes and/or emerging needs identified during the child welfare worker’s monthly visits with the child/youth. In addition, child welfare workers regularly discuss the child/youth’s physical and mental health status with the parent(s), placement provider, child/youth (if age appropriate), and other applicable team members during quarterly permanency planning reviews to ensure the child/youth does not have unmet or ongoing medical needs that require attention. During permanency planning reviews, the child/youth’s physical, dental, mental and behavioral health is discussed as well as any medication concerns or needs and information is documented on the Permanency Planning Review Form (DSS-5241). The child welfare worker is required to update the DSS-5207 Health History Form within 12 months of the child/youth entering foster care, and every 12 months thereafter.

Project Broadcast, a partnership between DSS and Center for Child and Family Health (CCFH) that began in 2009, focused on developing trauma-informed child welfare practice throughout the state. As a result, an assessment tool was developed that is used to identify signs of trauma in children entering foster care. To date, approximately 19,000 children have been screened using this tool. In addition, North Carolina continues to contract with CCFH to train child welfare staff to facilitate the National Child Traumatic Stress Network’s *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents (Resource Parent Curriculum)*. CCFH works with county child welfare agencies on building and sustaining trauma-informed child welfare practices. Each year, approximately 40 child welfare staff are trained as Resource Parent Curriculum facilitators.

DSS offers trauma informed training to both the child welfare workforce as well as foster and adoptive families through statewide staff development training. *Child Welfare in North Carolina: Pre-Service* is a competency-based curriculum that provides new child welfare

workers and supervisors an overview of the child welfare system in North Carolina, including the impact of trauma in the lives of the children and families served. *Trauma Screening 101* is a course developed by CCFH and the Family and Children’s Resource Program. This course introduces the Project Broadcast Trauma Screening Tool and covers how the tool is being used in North Carolina, the benefits of using the tool, and strategies to successfully implement the tool. *Child Development and the Effects of Trauma* is a training that focuses on developmental milestones, attachment, parenting styles, normal brain development, and the effects of trauma. *Trauma Informed Partnering for Safety and Permanence: Model Approach to Partnerships in Parenting (TIPS-MAPP)* is a preservice training for prospective foster and adoptive parents in North Carolina. TIPS-MAPP curriculum incorporates trauma-informed research, philosophy, language and practice to prepare foster/adoptive families for parenting children who have experienced trauma.

As North Carolina implements the Safety Organized Practice Model statewide, trauma-informed practice will further be integrated into the child welfare workforce.

### **Requirement 3 – Updating and Sharing Medical Information**

#### **Collecting Medical Information**

Immediately upon entry into foster care, the county child welfare worker is required by policy to begin gathering information to include on the Health History Form (DSS-5207), which is faxed to the medical home no later than one week prior to the 30-day Comprehensive Visit. Completion of the Health History Form is considered critical in assisting the medical provider to develop the best treatment plan to address the physical, behavioral, mental, and oral health needs of each child/youth. The Health History Form captures data on the child/youth’s developmental needs, behavioral/mental health, substance abuse history, and any medical and dental history, as well as present concerns. In addition, the form includes a detailed history of child welfare placements, birth family composition, prenatal risk factors, and certain safety concerns (e.g. domestic violence, alcohol abuse, etc.) that preceded placement into agency custody. Lastly, the form includes all contact information the medical provider may need, including the current resource, the child welfare worker, the assigned care manager, the Guardian ad Litem (if assigned), the dental home contact, most recent primary care provider to see the child, and any specialists that may be involved in the child/youth’s medical care. If available, the child welfare worker attaches any completed age-appropriate developmental screening records, documentation from previous health care providers, and/or the child/youth’s Individualized Family Service Plan or Individualized Education Plan from the Children’s Developmental Services Agency (CDSA) or the child/youth’s school. This compilation of health records is also shared with the placement provider. Child welfare workers update and redistribute the form annually, in conjunction with the mandated permanency planning review meeting.

#### **Electronic Access to Health Records**

North Carolina incorporates the use of multiple electronic systems in order to establish a comprehensive health picture of children/youth in foster care. CCNC and CMARC utilize *Virtual*

*Health* to provide a comprehensive view of the medical history of patients receiving care management services through their agency. Children and youth in foster care have been identified as a priority population for CCNC and CMARC and, as such, those receiving care management services will have ongoing Medicaid claims data available in *Virtual Health*, including medication fill history, visit history (including inpatient admissions, emergency department visits, office visits, and imaging history), pharmacy claims history, and laboratory results. In addition, *Virtual Health* has contact information for the care team (primary care provider, specialists, mental health services provider, member care coordinators, Durable Medical Equipment supplier, etc.) and care management notes. When psychotropic medication reviews are completed by the CCNC Network, the results of those reviews are also uploaded into *Virtual Health*.

County departments of social services may access *Virtual Health* by executing a participation agreement with CCNC. Authorized individuals in the county can use *Virtual Health* to see historical health information on children/youth in foster care. This timely access to information can be crucial when working with children/youth who have a physical or behavioral health care need that may require immediate attention (such as diabetes, asthma, or a mental health disorder) and where prescription medication may be required.

An additional tool to support the timely access of information for children/youth in foster care is North Carolina's pending statewide case management system, NC FAST. NC FAST fosters increased intercounty communication by drastically reducing the amount of time needed to transfer a child welfare case record when a family has a history of child welfare involvement in multiple counties. This increased functionality will extend to the maintenance of health records for children/youth in foster care as well. When NC FAST is fully functional, it is anticipated that a number of health-related data points will be included, such as the dates of medical appointments, medications prescribed, and medical diagnoses.

#### Sharing Information

In addition to the information sharing channels established through use of *Virtual Health* and NC FAST, copies of the health summary forms and all associated medical records (e.g. visit summaries) are given to the resource parent, and to each new primary care provider serving the child/youth in real-time. Throughout the life of the case, birth families (when parental rights are maintained) are provided with key physical, dental, and mental health information during the child specific portion of their case review, including the name of their child/youth's service providers, the dates of their last visits with each, and any action items that have been identified for follow-up. Child welfare workers are encouraged to provide copies of the child/youth's health records to the parent or custodian when permanency is achieved. The health forms are also provided to the youth if they exit foster care at or after age 18 (see [Requirement 8 - Ensuring Transition Plans Meet the Health Care Needs of Children Aging Out of Foster Care](#) for more detailed information).

#### **Requirement 4 – Ensuring Continuity of Health Services and Establishing Medical Homes**



North Carolina has embraced the Medical Home Model for children/youth served by the foster care program. DSS policy guidance states, “Whenever possible, the child’s connections and relationships with health care professionals should be maintained. This is especially true if the child has a previously established medical home. If the child comes into care without these connections, a medical home for the child should be established and maintained.” When a child/youth first enters foster care, the medical home must be documented in the child/youth’s record. This supports ongoing connections with health care providers and can help prevent any challenges with access to health care. The Fostering Health NC Program supports and implements this model by convening, educating, and training stakeholders. The three core stakeholders of the Foster Care Medical Home Model are county departments of social services, primary care providers, and care management entities (CCNC/CMARC). Each stakeholder has a distinct and important role in ensuring children/youth in North Carolina’s foster care program receive adequate services to meet their health needs.

The Foster Care Medical Home Model begins at the county department of social services where the Medicaid Eligibility staff ensure the child/youth is enrolled in a medical home. Through implementation of this model, county child welfare workers are encouraged to refer all children under age 5 to CMARC, and all children over age 5 to CCNC for care management. Within the Foster Care Medical Home Model, the county child welfare worker shares custody status information with the medical home and CCNC/CMARC to ensure continuity and coordination of health services. In many counties, this process is expedited through a tool called the “Custody Status Notification Form”.

The next core stakeholder of the Foster Care Medical Home Model is CCNC’s multidisciplinary team which may include Behavioral Health Coordinators, Pharmacists, Psychiatrists, and EPSDT Health Check Coordinators. CCNC Pharmacists provide medication reviews as requested by care managers, county child welfare staff, or primary care providers. CCNC/CMARC Primary Care Managers ensure there is coordination across regions when the child/youth is placed out of his/her home county. Additionally, care managers provide education and assist with continuity of health services through consultation with and education for primary care providers, county child welfare workers, resource parents, and the child/youth as age appropriate.

The Foster Care Medical Home Model’s final core stakeholder is the primary care provider. Under the Foster Care Medical Home Model, primary care providers are educated on the AAP’s enhanced well-visit schedule guidelines and the impact of toxic stress/trauma, accommodate timely access to initial visits, and schedule comprehensive visits within 30 days of the child/youth entering foster care. The primary care provider reviews medical records and health history provided by the county child welfare worker prior to the comprehensive visit.

By connecting children/youth in foster care to a medical home equipped to meet their health needs, North Carolina is better able to make sure children/youth’s physical, developmental, social-emotional, and oral health needs are identified and addressed, and that they receive the benefits of continuity of these health services. The Foster Care Medical Home Model ensures

children/youth in foster care receive high-quality and coordinated health services, including appropriate oversight of any needed prescription medications.

### **Requirement 5 – Protocols for the Appropriate Use and Monitoring of Psychotropic Medications and the Oversight of Prescription Medications**

NC Medicaid contracts with CCNC to provide care management services to the foster care population. CCNC’s data platform, *Virtual Health*, is an important tool used to help ensure the health and safety of children/youth in foster care. Each county department of social services is required to sign a Participation Agreement which allows the agency access to *Virtual Health*. This enables county child welfare staff the ability to view medical claims information and gather and preserve medical history of children/youth in foster care, including prescription medications.

DSS provides training to county child welfare staff through on-demand training courses. This two-course series provides knowledge and tools for collaborating with medical homes and local community care networks, and outlines expectations to address and improve health outcomes for children in foster care. In addition, CCNC provides an online training course, *Fostering Connections: Extra 1 Monitoring and Oversight of Psychotropic Medications*.

NCDHHS and FHNC collaborated with CCNC to support the development of two documents outlining the protocols for appropriate use and monitoring of prescription medication including psychotropic medication. The first document, [\*Best Practices for Medication Management for Children and Adolescents in Foster Care\*](#), was published in October 2015. Its companion document, [\*Psychotropic Medications in Children and Adolescents: Guide for Use and Monitoring\*](#), was published in March 2017 and updated in November 2018. To facilitate ongoing dissemination of these resources as a means of offsetting stakeholder turnover, FHNC staff provides these documents during trainings and stakeholder meetings. There is also a direct link to the resources on the FHNC online resource library.

The *Best Practices for Medication Management for Children and Adolescents in Foster Care* provides key information regarding medication oversight and monitoring, identifies “Reg Flag” Medication Review Guidelines and “High Alert” Medication Review Guidelines for child welfare workers, pharmacists, and prescribers. This publication includes a template to utilize when a child is transitioning into foster care or changing placements and outlines medication review pathways through the use of a flow chart. This publication also includes resources on North Carolina’s Community Pharmacy Enhanced Services Network, the A+KIDS program, and questions for child welfare workers or resource parents to ask of a provider who is prescribing psychotropic medication.

The *Guide for Use and Monitoring of Psychotropic Medications in Children and Adolescents* offers information for care managers, child welfare workers, or resource parents to use when they want to learn more about certain psychotropic medications. Specific information is outlined, including the therapeutic class, brand and generic names, FDA approved uses,

common evidence-based uses, potential side effects, and medication-specific safety/effectiveness monitoring necessary when a psychotropic medication is prescribed to a child or youth. This tool also contains information on A+KIDS and questions for child welfare workers or resource parents to ask of the prescribing provider.

North Carolina has several strategies to support the oversight and monitoring of prescription medication including:

- The Medical Home Model
- Community Pharmacy Enhanced Services Network
- Child Health Summary Components
- FHNC Online Resource Library
- FHNC Medication Workgroup
- A+ KIDS
- OSRI

#### *The Medical Home Model*

The Medical Home Model plays a key role in the oversight of prescription medication. When a child/youth is referred for care management through CCNC, a Nurse Care Manager reviews the referral information as well as any Medicaid claims data in *Virtual Health*, including medication claims. Care Managers gather a patient's reported lists of medications as well as review the medications in the patient's home for a medication reconciliation. Any discrepancies are found and reported back to the CCNC pharmacy team. Notifications to the filling pharmacy and primary care provider is completed.

A pharmacist comprehensive medication review is reserved for children/youth who are more complex. Pharmacists review medication reconciliations completed by care managers and perform comprehensive reviews to communicate medication issues to a child/youth's primary care provider with the goals of improving the quality of care, reducing preventable hospital readmissions and emergency department (ED) visits. CCNC pharmacists provide education, medication management services, coordination, and oversight of pharmacy benefits.

#### *Community Pharmacy Enhanced Services Network*

The Community Pharmacy Enhanced Services Network (CPESN) was developed in 2014 to broaden capacity for care management and medication optimization services, especially to sub-populations in greatest need, such as the foster care population. North Carolina pharmacists located in the Community Pharmacy Enhanced Services Network are equipped to conduct a medication review. Collaboration with a CPESN is designed to improve quality of care and child/youth outcomes related to optimal medication use, thereby improving the child/youth's overall health trajectory, leading to a reduction in total cost of care. In partnership with CCNC,

CPESN® pharmacies provide enhanced pharmacy services that go above and beyond conventional prescription dispensing and basic patient education. Enhanced services include interventions such as synchronization of a patient’s chronic medication fill dates, adherence monitoring and coaching, compliance packaging, and home delivery.

#### *Health Summary Components and other DSS Health Forms*

By utilizing the required child health summary component forms, the medical provider denotes whether a psychotropic medication review is requested or not during the Initial Visit and each subsequent Well-Visit. Medication is thoroughly reviewed during the 30-Day Comprehensive Visit. County child welfare workers obtain consent for necessary care and treatment through the use of the General Authorization for Treatment and Medication (DSS-1812). This form helps to ensure county child welfare agencies engage parents in the care and treatment of their children. This document provides guidance for county child welfare workers to discuss the use of prescription medications, including the use of psychotropic medication. The health summary components are a tool to be used in the coordination of care of the foster child/youth. They should provide information to the CW worker, Care Manager, caregiver/resource parent and parent and all involved in the life of the child/youth to guide care plans and goals related to health/well-being. In addition, the North Carolina Permanency Planning Review form (DSS-5241) is a documentation tool used during Permanency Planning Reviews every 90 days. During the reviews, the child/youth’s permanency planning action team reviews the child’s current medical status, including medications.

#### *FHNC Online Resource Library*

The Fostering Health NC Resource Library is a resource for child welfare staff and any stakeholders involved in the life of a child/youth in foster care. There is a Medication section in addition to many other topics. This section holds *Best Practices for Medication Management for Children and Adolescents in Foster Care* as well as the *Psychotropic Medications in Children and Adolescents: Guide for Use and Monitoring* documents. There is also information related to best practices and AACAP guidance.

#### *FHNC Medication Workgroup*

The FHNC workgroup on medication has been established and is comprised of board-certified Child and Adolescent Psychiatrists, staff from NC Medicaid, DSS, CCNC, the University of North Carolina at Chapel Hill (DSS’ evaluation partner), and a variety of other stakeholders. The Medication Workgroup meets every other month to discuss matters regarding the oversight of prescription medicines, including the established protocols for the appropriate use and monitoring of psychotropic medications.

#### *A+ KIDS*

In 2011, NCDHHS partnered with CCNC to implement a registry, called A+KIDS (Antipsychotics - Keeping It Documented for Safety), to document the use of antipsychotic therapy in NC Medicaid and NC Health Choice beneficiaries ages 0 through 17. A+KIDS was created due to

well-documented safety concerns and limited information about the efficacy of using antipsychotic agents in children. The registry encouraged the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of antipsychotics in this population. This program ensured that prescribers documented the efficacy of therapy, side effects, and metabolic monitoring necessary for continued use of antipsychotic medications.

In June 2015, A+KIDS was embedded into the NC Tracks, the new multi-payer Medicaid Management Information System for NCDHHS. Providers document information regarding the efficacy of therapy, side effects, and metabolic monitoring parameters (height/weight/BMI percentile, lipid panel, and blood glucose). Once the information is submitted to the NC Tracks web-based portal or phoned in successfully, the medication is authorized for 6 months.

#### *Additional Requirements Regarding Psychotropic Medication Monitoring*

NC Child Welfare policy requires children/youth in foster care to have a mental health evaluation (including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication) within 30 days of entering foster care; followed by ongoing monitoring and assessment as needed.

North Carolina has established administrative rules that support appropriate use and monitoring of prescription medication at the client level. These policy guidelines require foster parents (both DSS family foster homes and independently licensed family and therapeutic foster homes) to maintain a Medication Administration Record (MAR), provide guidance on who has the authority to administer medication, safe storage, and instructions for ongoing metabolic monitoring needs. It is the responsibility of the foster home's supervising agency to regularly review the MAR for changes, errors, etc. and to ensure that licensed medical professionals are appropriately consulted regarding both prescribed and over-the-counter medication. Additional requirements regarding Medication can be found in the [Foster Home Licensing Manual](#), beginning on page 73.

#### *Onsite Review Instrument*

NC utilizes the Onsite Review Instrument (OSRI) to monitor adherence to prescription medication oversight of children and youth in foster care. OSRI case reviews conducted in the last two measurement periods (May 2018 through April 2019) indicate that the agency provided appropriate oversight of prescription medications for the physical health issues of the target child in foster care in 92% of cases reviewed. For the same time period the agency provided appropriate oversight of prescription medications for the mental/behavioral health issues of the target child in foster care in 100% of cases reviewed.

### **Requirement 6 – Coordination and Collaboration with Experts for the Health and Medical Treatment of the Foster Care Population**

#### **Individual Level Coordination**

Through the Fostering Health NC Program and the Foster Care Medical Home Model, DSS has a robust infrastructure to ensure the state has ongoing and meaningful engagement and consultation with the medical community regarding the appropriate treatment for children served by the foster care program. This includes the primary care physician, the care coordination entity, and additional service providers as outlined in [Requirement 2](#).

To assist coordination on the individual level further, children under the age of three who exhibit possible developmental delays or who have been identified as a substance affected infant are referred to the local Children's Developmental Services Agency (CDSA) for early intervention using the CDSA Referral Form (DSS-5238).

Child welfare workers complete the North Carolina Family Assessment of Strengths and Needs (DSS-5229) and if the "Child Characteristics" identify any concerns, a referral to a CDSA is completed. Concerns can include the appearance or presence of an established condition or developmental delay or a likelihood that a child has a mild delay in the areas of cognition, physical development (including fine and gross motor function), communication, social-emotional, and/or adaptive development.

The North Carolina Pediatric Access Line (NC-PAL) is a telephone consultation program to help pediatric health care providers in select rural counties address the mental health needs of children and adolescents. Providers can call the NC-PAL line when they have questions about pediatric mental health. The provider is connected first with a resource specialist that will respond to questions within the scope of their expertise. If needed, the specialist will connect providers to a child and adolescent psychiatrist for further consultation.

There is also a board-certified child psychiatry team on hand to assist with diagnostic clarification and medication management. This team provides the following services:

- Consultation on diagnoses, medications and psychotherapy interventions for a wide range of behavioral health needs (e.g. mental health care guides, screening forms),
- Connection with community resources (e.g. intensive in-home providers, support groups),
- Information on government programs (e.g. enrolling families for Food and Nutrition Services, CDSA, CMARC),
- Guidance on behavioral health issues, autism spectrum disorders, intellectual and developmental disabilities.

In addition to telephone consultation, NC-PAL provides access to screening forms, educational resources, and additional information to support the needs of PCPs. Providers can access helpful mental health care guides at any time on the NC-PAL website (<https://ipmh.duke.edu/content/ncpal>).

### Systemic Coordination

The Fostering Health NC State Advisory Team is comprised of multiple stakeholders from a variety of disciplines including pediatricians, family physicians, care managers, pharmacists, and other clinical specialists from agencies including NC Medicaid, North Carolina Division of Mental Health, Guardian ad Litem, recipients of child welfare services, and others. The State Advisory Team or its workgroups meet monthly, working collaboratively to improve systems of care for children/youth in the child welfare system. Collaborations among county child welfare agencies, medical practices, and care management entities – all coordinated by the FHNC Program – are key to ensuring all youth in foster care receive high-quality, coordinated health care services.

The FHNC State Advisory Team assists DSS in the development of health-related policy and forms to document health information. The State Advisory Team develops a variety of resources including best practices documents, educational materials and other resources for a wide range of stakeholders. These key health-related documents are housed within FHNC’s online resource library, along with several other health-related resources ([www.ncpedcs.org/fosteringhealthnc](http://www.ncpedcs.org/fosteringhealthnc)).

North Carolina released an Early Childhood Action Plan (ECAP) in February 2019. This plan defines how NCDHHS, in collaboration with stakeholders, will improve health and well-being of children in North Carolina. The HOCP aligns with specific goals outlined in the ECAP including increasing access to preventative health services and accurately assessing and treating social-emotional needs of children. For more detailed information about North Carolina’s Early Childhood Action Plan please visit <https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-action-plan>.

The Division of Social Services collaborates with the Division of Public Health and other stakeholders to address the *Plan of Safe Care* programming requirement (which is not discussed in detail in this document). For more information on the *Plan of Safe Care* programming, please visit <https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/infant-plan-safe-care>.

### **Requirement 7 – Addressing Trauma and Preventing Inappropriate Mental Health Diagnoses**

The North Carolina Child Treatment Program (CTP) is training clinicians in trauma-informed assessments and several trauma-informed, evidence-based models to treat the trauma associated with maltreatment and placement into foster care. The CTP Roster, which currently houses over 600 providers statewide, provides brief descriptions of each treatment modality to assist in selecting the best fit according to the child/youth’s needs. These treatments include SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress), Parent-Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Attachment and Biobehavioral Catch-up (ABC). Physicians, child welfare workers, and resource parents are encouraged to use the CTP *Roster* (<https://ncchildtreatmentprogram.org/roster.php>) to identify trained clinicians in their area.

DSS is training child welfare workers and resource parents on the impact of trauma and how to best address it through trauma-informed child welfare practice. There are five online courses,

six classroom courses, and five blended courses (including two learning communities) that focus on trauma-informed programming. DSS has implemented a one-page trauma screening tool which can be completed by child welfare workers. The completed Project Broadcast Trauma Screening Tool should be included in the documentation provided to the medical or mental health provider to assist in developing a treatment plan that can address any trauma-related needs. As of May 2019, North Carolina has screened more than 30,000 children/youth using the Project Broadcast Trauma Screening tool and used the information to help inform child welfare practice, placements, case plans, and referrals to clinicians.

Children/youth in foster care who have trauma histories and/or are exposed to toxic stress are at higher risk for social-emotional delays. Social-emotional development is impacted early and, if ignored, can lead to long term problems with health and behavior. Over the last decade, North Carolina's birth to five child welfare population has remained steady, averaging 39%.<sup>5</sup> As such, there is tremendous opportunity for the foster care program and its partners to identify and address concerns early, thereby mitigating the negative effects of trauma on health and development.

The medical visit schedule established for initial and follow-up health screenings offer the system an additional opportunity to identify and address concerns related to the child/youth's trauma exposure, including mental health, behavioral health, or substance use issues. The mandated forms help to identify health needs and ensure they are properly treated and monitored according to EPSDT standards. For example, child welfare workers are encouraged to complete several developmental screening tools when available such as the ASQ-3 (Ages and Stages Questionnaire® Social-Emotional), PEDS (Parents' Evaluation of Developmental Status), PSC (Pediatric Symptom Checklist), or the Bright Futures Supplemental Questionnaire or PSC-Y prior to the 30-day Comprehensive Visit. These are shared with the medical provider during the 30-day Comprehensive visit. Sharing the results with other partners in the Medical Home Model (the CCNC/CMARC Care Manager and the DSS professional) help to ensure that treatment plans are adequately monitored.

To further assist in this systemwide effort to reduce the effects of childhood trauma, the FHNC staff routinely train child welfare staff, medical providers and support personnel, CCNC/CMARC care managers, and other stakeholders in trauma-informed care and the impact of trauma.

North Carolina has several strategies to address the trauma associated with child maltreatment and placement in foster care. As mentioned previously, the use of screening tools to identify issues such as anxiety, depression, substance use, or other social-emotional issues can help to identify trauma symptoms, which could prompt a referral to a mental health clinician to conduct a Trauma-informed Comprehensive Clinical Assessment. FHNC has also posted several resources online for providers, child welfare workers, and resource parents regarding how to identify and respond to trauma.

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<sup>5</sup> <http://ssw.unc.edu/ma/> (accessed May 2019)



To further add to DSS's efforts to be trauma-informed and prevent misdiagnosis, the North Carolina Child Medical Evaluation Program (CMEP) provides a structured system for medical and mental health evaluations in cases of alleged child maltreatment. The primary goal of the program is the provision of diagnostic services to be used by county DSS agencies in child protective service investigations. DSS policy indicates a CMEP and/or CFEP evaluation should be considered if the county child welfare worker has questions about any of the following issues:

- Significant delay in the child's developmental skills;
- Significant delay in the child's physical development;
- Unusual and unexplained lethargy or irritability;
- Untreated or inadequately treated medical conditions which have significant impact on the child's overall health or physical development;
- Children affected when one parent abuses the other;
- Sexual contact between children initiated as a CPS assessment for parental supervision issues;
- A child has received a non-serious injury from an unknown perpetrator; or
- Other instances in which a CMEP and/or a CFEP may be considered appropriate as part of the CPS Assessment.

Each child medical evaluation (CME) consists of a medical/social history, interviews of the child and accompanying caregiver, and a complete physical examination. There can also be a mental health component, known as the Child/Family Evaluation (CFE), intended to provide extended evaluations. The objectives of these evaluations are (1) to assist with disclosure and decision making in cases that cannot be substantiated through medical evaluation or child welfare worker investigation and (2) to determine caretaker capacity/child safety. This program is a comprehensive way to identify trauma associated with child maltreatment, and its coordinated effort to gather information from multiple parties at once in a child-centered environment helps prevent the retraumatization that can often occur with multiple in-depth interviews. For more information on the CMEP program, visit <https://www.med.unc.edu/cmep/>.

### **Requirement 8 – Ensuring Transition Plans Meet the Health Needs of Youth Aging Out of Foster Care**

North Carolina's child welfare program is committed to ensuring that every young person has a planned health care transition to maximize his/her well-being and optimize his/her ability to assume adult roles and activities. Each youth transitioning to adulthood requires specific and individualized support in order to transition successfully to adult-oriented health care. This process includes ensuring that high-quality, developmentally appropriate health care services are available in an uninterrupted manner as the youth moves from adolescence to adulthood.

By utilizing the Foster Care Medical Home Model, providers and others involved can assist the youth and county child welfare workers in developing a plan for transition from pediatric care to adult care. Independent Living Services for Foster Children (NC LINKS) provides services and resources to youth and young adults ages 13-21 who are currently or formerly in the foster care

program. NC LINKS provides a network of relevant services for youth so that they will have ongoing connections with family, friends, mentors, the community, and employers; it also provides education, financial assistance, skills training, and other resources to facilitate their transition to adulthood. LINKS Coordinators and county child welfare workers collaborate with the youth to develop their Transitional Living Plans (TLPs). As set forth in DSS policy, the TLP must be developed, reviewed, and updated according to the following table.

Youth turning 14	Youth age 14 or Older
<ul style="list-style-type: none"> <li>• Developed no more than 30 days following the youth’s 14th birthday;</li> <li>• Reviewed within 60 days of the youth’s 14th birthday;</li> <li>• Updated at least every 90 days thereafter</li> </ul>	<ul style="list-style-type: none"> <li>• Developed within 30 days of the youth entering custody if they are 14 years old or older;</li> <li>• Reviewed within 60 days of the youth entering custody if they are 14 years old or older;</li> <li>• Updated at least every 90 days thereafter,</li> </ul>

The Transitional Living Plan (Documented on forms DSS-5096b, and DSS-5096c) takes great care to ensure the health needs of youth aging out of foster care are met. Options about health insurance, including health insurance resources, provider information, and contact information for health care resources, are discussed in a youth driven meeting, in which a young person takes an active role in identifying supportive adults they wish to invite. The resources identified are outlined on the corresponding forms. Additionally, the DSS-5096b and DSS-5096c forms are utilized to engage youth in conversation about the need for a health care power of attorney and/or health care proxy and to empower youth to execute such an agreement upon exiting care. The forms also document that the youth has received information and/or assistance regarding applying for Medicaid or other state/federally funded health insurance.

The goal in North Carolina is for every youth and young adult who lives or has lived in foster care as a teenager to achieve the following outcomes, identified by the federal government to monitor the effectiveness of Chafee-funded independent living services, by age 21. The seven identified objectives are:

- All youth leaving the foster care system shall have sufficient economic resources to meet their daily needs.
- All youth leaving the foster care system shall have a safe and stable place to live.
- All youth leaving the foster care system shall attain academic or vocational/educational goals that are in keeping with the youth’s abilities and interests.
- All youth leaving the foster care system shall have a sense of connectedness to persons and community. This means every youth, upon exiting foster care, should have a personal support network of at least 5 responsible adults who will remain supportive of the young adult over time.
- All youth leaving the foster care system shall avoid illegal/high risk behaviors.
- All youth leaving the foster care system shall postpone parenthood until financially established and emotionally mature.

- *All youth leaving the foster care system shall have access to physical and mental health services, as well as a means to pay for those services (Italics added).*

LINKS Coordinators assist with linking transition age youth with community resources such as Strong Able Youth Speaking Out (SAYSO). SAYSO is a statewide association of youth aged 14 to 24 who are, or have been, in county DSS custody in North Carolina, whether placed in family foster care, group care, or mental health facilities. Counties can utilize LINKS support groups and/or SAYSO to develop youth-led recommendations on what youth need to know prior to the transition planning session. These activities and recommendations assist the youth in developing their own transition plans.

### Section III. 2020-2024 Commitments and Targets

<b>Health Care Oversight and Coordination Commitment</b>	
Commitment: North Carolina will strengthen and improve the health care oversight of children, youth and young adults in foster care.	

<b>Target 1: Ensure the process to oversee the healthcare of children and youth in foster care is streamlined across the child welfare workforce and the medical community</b>	
Description	North Carolina will ensure health care oversight is streamlined among child welfare agencies, physical and behavioral health providers, CCNC and NC Medicaid in order to provide seamless, person-centered care to children and youth in foster care by embedding content in existing training curriculum and developing educational materials in an effort to increase the number of referrals made to CCNC for care management.
Rationale	Seamless, person-centered care is critical to the long-term well-being of children in foster care. Coordination of care across physical and behavioral health providers, child welfare agencies, NC Medicaid, CCNC, and CMARC must be streamlined. Further, health care information must be shared in a coordinated way among entities and providers to ensure the healthcare needs of children in foster care are being met in a timely manner.
<b>Strategies</b>	
	<b>1a.</b> Devote a FTE to statewide health care oversight to begin October 2019.
	<b>1b.</b> Incorporate health programming content into core training for child welfare staff and resource parents.
	<b>1c.</b> Develop and publish additional health care resources for the FHNC Resource Library that promote best practices for meeting the health care needs of children and youth in foster care.
Benchmarks	<b>2021:</b> Increase the number of available educational materials specific to best practices regarding connecting children and youth in foster care to a medical home and referring them to CCNC and CMARC for care management services.
	<b>2021:</b> Embed content regarding health programming into core trainings including but not limited to: <i>Child Welfare Services in North Carolina: Pre-Service</i> and <i>Trauma Informed Partnering for Safety and Permanency: Model Approach for Partnerships in Parenting (TIPS-MAPP)</i> .
Metrics	By 2022, child welfare workers and the medical community will understand the process in assuring streamlined and integrated health care oversight for children and youth in foster care in North Carolina.
Staff Training, Technical Assistance, and Evaluation/Research	Staff Training: Training and education is supported by Fostering Connections I and Fostering Connections II (online courses).  Technical Assistance: Counties are supported via FHNC Implementation Specialists; the Children’s Program Representatives; and the staff at Community Care of North Carolina.  Evaluation: DSS in partnership with FHNC evaluate barriers to access to and delivery of health care services to children and youth in foster care.
Implementation Supports	This target will be driven by DSS, in partnership with FHNC, the Statewide Advisory Team in collaboration with NC Medicaid, UNC School of Social Work, Community Care of North Carolina, and county child welfare agencies. It will be supported by DSS training, SAYSO, and the FHNC Online Resource Library.  Implementation supports needed include the development of educational materials for child welfare workers, Medicaid Eligibility staff and youth, resource parents, and strengthening the data exchange protocols between NC Medicaid and DSS. These supports are anticipated to be in place by 2022.

<b>Target 2: Strengthen Transition Age Youth Health Programming</b>	
Description	Youth transitioning to adulthood will have the knowledge, skills, and resources to help them achieve self-sufficiency to successfully manage their own physical, dental, social-emotional, and behavioral health needs.
Rationale	A significant portion of youth exiting the foster care program face serious difficulty transitioning to life on their own. In addition to the typical financial, housing, and employment issues young adults navigate, individuals exiting foster care have higher rates of adverse childhood experiences and are therefore at greater risk of criminal justice involvement, falling victim to human trafficking, and/or experiencing early pregnancies. By ensuring that young adults can manage their own health, North Carolina can mitigate the negative health outcomes associated with the foster care population, often changing intergenerational health patterns. Rylan’s law specifically requested recommendations for those youth aging out of the foster care system, and the third-party evaluation found that these youth are not consistently being prepared for adulthood. Additionally, AAP stressed the importance of health care transition in a recent clinical report. Finally, a preliminary gap and needs analysis confirmed the need to strengthen health programming for these emerging adults to ensure DSS is fully in compliance with federal regulations regarding health oversight and coordination specifically for transition age youth.
	<b>Strategies</b>
	<b>2a.</b> Strengthen protocol and guidance on informed and shared decision-making regarding healthcare.
	<b>2b.</b> Develop resources for transition age youth in foster care including educational materials and literature on health programming for statewide distribution. This will be in the form of a health passport.
Benchmarks	<b>2020:</b> Engage SAYSO and medical stakeholders in the develop, review and update of protocol and guidance on informed and shared decision-making. <b>2021:</b> Publish and distribute protocol and guidance on informed and shared decision-making developed as a result of focus groups. <b>2021:</b> Through collaboration with NC Medicaid, SAYSO, and other stakeholders, create educational resources for transition age youth on healthcare power of attorney, transitioning to an adult medical home, applying for Medicaid, and other health programming.
Metrics	By 2024, all youth and young adults exiting foster care in North Carolina will have a packet of information, referred to as a “Health Passport”, that includes their health history, medical home provider, power of attorney, and other important health care information.
Staff Training, Technical Assistance, and Evaluation/Research	Staff Training: Programming is currently supported by Fostering Connections I, Fostering Connections II, Fostering Connections Extra: Transitioning Youth to Adult Medical Care (online courses), and program specific in-person staff trainings provided by FHNC Implementation Specialists. The FHNC Online Resource Library has training supports for DSS staff and health providers.  Technical Assistance: Counties are supported via FHNC Implementation Specialists; the Children’s Program Representatives; and the staff at Community Care of North Carolina. This target will be driven by the FHNC’s Transition Age Workgroup in collaboration with NC Medicaid, UNC School of Social Work, Community Care of North Carolina, and county departments of social services. It will be supported by DSS training, SAYSO, NC Reach Coordinators, and the FHNC Online Resource Library.  Evaluation: DSS in partnership with NC Medicaid, FHNC and the FHNC Transition Age Workgroup will evaluate barriers to Medicaid Eligibility and seamless transition to adult medical homes for transition age youth.
Implementation Supports	This target will be driven by DSS, in partnership with FHNC and the FHNC Transition Age Workgroup. It will be supported by NC Medicaid, UNC School of Social Work, Community Care of North Carolina, and county departments of social services. It will be supported by DSS training, SAYSO, NC Reach Coordinators, and the FHNC Online Resource Library.

**Target 2: Strengthen Transition Age Youth Health Programming**

	Implementation supports needed include the development of educational materials for child welfare workers, Medicaid Eligibility staff and youth, resource parents, and strengthening the data exchange protocols between NC Medicaid and DSS. These supports are anticipated to be in place by 2022.
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**Target 3: Strengthen Protocols for Monitoring of Psychotropic Medications at the Local Agency Level**

Description	North Carolina will review and update protocols, guidance, training, and resources to provide clarity to the child welfare workforce, the medical community, and resource parents to properly execute medication oversight and monitoring at the local agency level.
Rationale	North Carolina relies on the use of the Medical Home model and contract with CCNC to monitor psychotropic medications prescribed to children and youth in foster care. While there are resources and training available to child welfare staff, the roles and responsibilities of the primary care provider, care manager and child welfare worker need to be addressed. Although North Carolina requires county child welfare workers to be trained on the use of psychotropic medications and training options are provided, content needs to be included in core trainings for child welfare staff and resource parents such as pre-service trainings.
	<p><b>4a.</b> Review and update protocols regarding medication utilization, including assent/consent issues, side effects, metabolic monitoring, interaction with trauma and misdiagnosis, etc. for child welfare workers regarding their role in management of psychotropic medications.</p> <p><b>4b.</b> Include education and training for child welfare workers and resource parents regarding medication utilization, collaboration and informed decision-making, and strategies to prevent misdiagnosis.</p>
Benchmarks	<p><b>2020:</b> Conduct a gap and needs analysis on the Child Welfare Manual specific to health programming and psychotropic medication oversight requirements and align with federal laws and regulations accordingly.</p> <p><b>2021:</b> Develop additional trainings and resource materials to provide education about medication oversight and monitoring programming for transition age child welfare workers.</p> <p><b>2021:</b> Develop additional trainings and resource materials to provide education about medication oversight and monitoring programming for transition age youth and young adults.</p>
Metrics	By 2022, DSS will have robust resources in place to support local agencies in the oversight and monitoring of psychotropic medications of children/youth in foster care, including policies, protocols, guidance and training, that align with federal laws and regulations.
Staff Training, Technical Assistance, and Evaluation/Research	<p><b>Staff Training:</b> Programming is currently supported by Fostering Connections I and Fostering Connections II (online courses).</p> <p><b>Technical Assistance:</b> Counties are supported via FHNC Implementation Specialists; the Children’s Program Representatives; medication specific documents on the FHNC Online Resource Library, and the staff at Community Care of North Carolina.</p> <p><b>Evaluation:</b> DSS in partnership with NC Medicaid, FHNC and the FHNC Medication Workgroup will conduct a gap and needs analysis to identify recommendations regarding medication utilization.</p>
Implementation Supports	This target will be driven by DSS, in partnership with FHNC and the Medication Workgroup in collaboration with NC Medicaid, UNC School of Social Work, Community Care of North Carolina, and county departments of social services. It will

	<p>be supported by DSS training, SAYSO, NC Reach Coordinators, and the FHNC Online Resource Library.</p> <p>Implementation supports needed include the development of educational materials for child welfare workers, Medicaid Eligibility staff and youth, resource parents, and strengthening the data exchange protocols between NC Medicaid and DSS. These supports are anticipated to be in place by 2022.</p>
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## Section IV. Supporting Information and Documentation

### Key Resources

AAP Standards of Care	<a href="https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf">https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf</a>
AACAP Practice Parameters	<a href="https://www.jaacap.org/article/S0890-8567(15)00148-3/pdf">https://www.jaacap.org/article/S0890-8567(15)00148-3/pdf</a>
Health Check Guide	<a href="https://medicaid.ncdhhs.gov/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services">https://medicaid.ncdhhs.gov/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services</a>
ACF Guidance	ACF Medication Guidance <a href="https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf">https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf</a> and <a href="https://www.childwelfare.gov/pubPDFs/jointlettermeds.pdf">https://www.childwelfare.gov/pubPDFs/jointlettermeds.pdf</a>
GAO Reports	HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions ( <a href="https://www.gao.gov/assets/590/586906.pdf">https://www.gao.gov/assets/590/586906.pdf</a> )  HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration ( <a href="https://www.gao.gov/assets/690/681916.pdf">https://www.gao.gov/assets/690/681916.pdf</a> )
Office of Inspector General	Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication ( <a href="https://oig.hhs.gov/oei/reports/oei-07-15-00380.pdf">https://oig.hhs.gov/oei/reports/oei-07-15-00380.pdf</a> )

### Acknowledgement

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### Public Notice

This 2020-2024 Health Care Oversight and Coordination Plan (revised 2019) is posted on the Program Statistics and Reviews page of the North Carolina Division of Social Services website (<https://www.ncdhhs.gov/divisions/social-services/program-statistics-and-reviews/child-welfare-statistics>). It is also a part of North Carolina's five-year Child and Family Services Plan (CFSP). Progress and accomplishments implementing this Health Care Oversight and Coordination Plan can be found in North Carolina's most recent Annual Progress and Services Report (APSR) located on <https://www.ncdhhs.gov/divisions/social-services/program-statistics-and-reviews/child-welfare-statistics>.

If you would like to get involved in child welfare health programming, please visit the Fostering Health NC Program at <https://www.ncped.org/fosteringhealthnc> to learn more.



Comments or questions should be directed to:

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