



North Carolina Foster Care Health Oversight and Coordination Plan

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INTRODUCTION

The North Carolina Division of Social Services entered into a contract with the North Carolina Pediatric Society in October 2012 to develop a Health Oversight & Coordination Plan (HOCP) for North Carolina as required by the federal law, *Fostering Connections to Success and Increasing Adoptions Act of 2008*.

The co-authors of the HOCP are Dana Hagele and Leslie Starsonneck. Dr. Hagele is a pediatrician with a particular interest and expertise in the area of child abuse and established the NC Child Treatment Program. Leslie Starsonneck works as a private consultant in Raleigh and is a part time employee of the NC Pediatric Society where she focuses on developing and overseeing pilot projects to connect children in foster care to medical homes with the capacity to identify and meet their needs. The NC Pediatric Society entered into a sub-contract with Dr. Allan Chrisman to draft the section of the HOCP on psychotropic medications. Dr. Chrisman is a member of the A+ KIDS registry's Advisory Board and an Associate Professor of Psychiatry at the Duke Child & Family Study Center, Division of Child & Adolescent Psychiatry, Department of Psychiatry & Behavioral Sciences. Susan Cohen contributed to the HOCP sections on the demographics of the foster care population and transition plans for youth aging out of foster care while she was an intern at Community Care of North Carolina.

Section 1 of this document contains the Health Oversight & Coordination Plan (HOCP). Section 2 contains the recommended infrastructure to support implementation of the North Carolina HOCP. Section 3 contains background sections on key issues including educational stability, medical homes, oral health, and youth transitioning out of care, that provide additional information on needs and recommended standards (not included in this document).

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Section I: The North Carolina Foster Care Health Oversight and Coordination Plan

Infants, children and youth in the North Carolina foster care system meet criteria for *children with special care needs* (CWSHN).¹ Specifically, they demonstrate disproportionately high rates of physical, reproductive, oral/dental, developmental, behavioral-emotional, cognitive, educational, and social dysfunction compared to the general child population. Medicaid eligibility is authorized for all foster children living in North Carolina who receive adoption assistance or foster care payments through Title IV-E Adoption and Foster Care assistance.² Per federal Medicaid requirements, foster children are entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits which include comprehensive screening, as well as medically necessary services, products, or procedures if requested by a physician or licensed clinician.³

Federal Requirements of the HOCP:

- ✓ *Health screening schedule*
- ✓ *Protocol to assess, treat and monitor health needs*
- ✓ *Protocol to assess, treat and monitor emotional trauma*
- ✓ *Electronic health record*
- ✓ *Network of medical homes*
- ✓ *Prescription medication oversight protocol*
- ✓ *Health consultation protocol*
- ✓ *Educational support*
- ✓ *Transition plan for youth aging out of care*

Children in foster care also incur greater health care costs compared to their age-matched peers enrolled in the state's Medicaid program.^{4 5} Despite higher health-related expenditures, children residing in state custody often continue to demonstrate poor health and well-being outcomes. As custodians of this special needs group, the state must develop a health oversight and coordination plan, as well as an infrastructure, to ensure their safety, permanency and optimal health and well-being.

¹ Ringeisen H, Casanueva C, Urato M, Cross T. Special health care needs among children in the child welfare system. *Pediatrics* 2008;122(1): e232 – 4.

² NC DHHS Policy Manual. Family and Children's Medicaid MA-3230 Eligibility of Individuals Under 21; IV Policy Rules – Title IV E Individuals Under 18. Available at: <http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/MA3230-05.htm>

³ NC DHHS, Division of Medical Assistance, Medicaid Eligibility Unit: Aged, blind, and disabled Medicaid Eligibility Manual MA-2905, Medicaid Covered Services 1, Revised 08/01/11 – Change no. 16-11. Available at: http://info.dhhs.state.nc.us/olm/manuals/dma/abd/chg/MA_CN16-11_2905.pdf

⁴ Center for Health Care Strategies (2008). Medicaid Managed Care for Children in Child Welfare. Issue Brief. Accessed at http://www.chcs.org/usr_doc/CW_MC_Brief.pdf.

⁵ Data from a NC Pediatric Society pilot program at Wilmington Health indicate that the health care costs of fostered children are about 9 times the cost (per member per month) as non-fostered children in the Medicaid population.

The *Fostering Connections to Success and Increasing Adoptions Act of 2008* requires the state to develop a Foster Care Health Oversight and Coordination Plan (HOCP) under the leadership of the Division of Social Services (NC DSS), the Division of Medical Assistance (NC DMA), and medical experts.⁶ The HOCP must ensure a coordinated strategy to identify and respond to the health care needs of children in foster care, including mental health and dental health needs. Furthermore, the HOCP must include:

- A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
- A protocol to screen, assess, monitor and treat identified health needs. Additionally, the protocol must screen, assess, monitor, and treat the emotional trauma⁷ associated with a foster child's maltreatment and removal;
- An electronic health record, including critical medical information, routinely updated and shared per standardized protocols;
- A network of medical homes that meets accepted medical standards, assuring continuity of health care standards;
- A protocol that allows for oversight of all prescription medications across the foster care population⁸, including a protocol to assure the appropriate use and monitoring of psychotropic medication;⁹
- A protocol whereby DMA, NC DSS, local departments of social services actively consult with physicians and other professionals to assess the health and well-being of , and to determine appropriate medical treatment for, children in foster care.

In addition:

- *Fostering Connections to Success and Increasing Adoptions Act of 2008* requires states to address the educational stability of each child in foster care through individual service plans.¹⁰
- The *Patient Protection and Affordable Care Act of 2010* (P.L. 111-148) requires each state to develop a protocol to ensure that transition plans for youth aging-out of foster care include information about: health insurance options, health care powers of attorney, and health care proxies.¹¹

⁶ *Fostering Connections to Success and Increasing Adoptions Act of 2008* (P.L. 110-351)

⁷ *Child and Family Services Improvement and Innovation Act of 2011* (P.L. 112-34)

⁸ *Fostering Connections to Success and Increasing Adoptions Act of 2008* (P.L. 110-351)

⁹ *Child and Family Services Improvement and Innovation Act of 2011* (P.L. 112-34)

¹⁰ *Fostering Connections to Success and Increasing Adoptions Act of 2008* (P.L. 110-351)

¹¹ *Patient Protection and Affordable Care Act of 2010* (P.L. 111-148)

NC Foster Care Health Oversight and Coordination Plan

Summary of Federal Requirements

Screening, Assessment, Monitoring and Treatment

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, receive an initial health (including oral health) and emotional trauma screening that meets reasonable standards of medical practice.

The state shall ensure that each foster child receive follow-up health and emotional trauma screening, as well as ongoing assessment, monitoring and treatment of identified health needs, according to reasonable standards of medical practice.

Foster Care Well-Being Passport

The state shall generate an electronic health record for each infant, child and adolescent upon entry to foster care, including critical medical information which is routinely updated and shared according to standardized protocols.

Medical Home Network

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, benefit from comprehensive care through a network of medical homes that meets accepted standards, assuring continuity of health care standards.

Prescription Medication Oversight

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, benefit from oversight of prescription medication use, including appropriate, effective use and monitoring of psychotropic medication.

Well-Being Consultation Protocol

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, benefit from health and well-being oversight through a consultation protocol established between NC DMA, CCNC, NC DSS, local departments of social services and other state entities – and physicians and other experts.

Educational Health

The state shall ensure that each child and adolescent will, upon entry into foster care, benefit from an individual service plan that specifically assures educational stability, and provides educational and vocational coordination and support.

Transitional Plan for Youth Aging-Out of Foster Care

The state shall ensure that each adolescent will, upon entry into foster care, benefit from a transition plan that assures they will receive information addressing: health insurance options; health care powers of attorney; and health care proxies.

Screening, Assessment, Monitoring and Treatment

Per federal legislation, *Fostering Connections to Success and Increasing Adoptions Act of 2008*, the North Carolina foster care Health Oversight and Coordination Plan (HOCP) must include the following provisions:

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, receive an initial health (including oral health) and emotional trauma screening that meets reasonable standards of medical practice.

The state shall ensure that each foster child will receive follow-up health and emotional trauma screening, as well as ongoing assessment, monitoring, and treatment of identified health needs, per reasonable standards of medical practice.

It is recommended that a protocol be developed to address foster care health and well-being screening, assessment, monitoring, and treatment based upon: Medicaid EPSDT standards (Early and Periodic Screening, Diagnosis and Treatment); best practice standards established by the American Academy of Pediatrics (AAP)¹²; and standards established by the Child Welfare League of America (CWLA)¹³ whereby:

I. Well-Being Visit Frequency

Each infant, child and adolescent should be evaluated by medical personnel, preferably within their medical home, upon entry into foster care per the following accelerated schedule:¹⁴

- Health screening within 72 hours of placement;
- Comprehensive health evaluation within 30 days of placement;
- Follow-up evaluation and treatment within 60-90 days of placement.

Each infant, child and adolescent should participate in frequent health and well-being evaluations, within their medical home, as follows:

- Monthly for infants birth to 6 months of age;
- Every three months for children 6 to 24 months of age;
- Every six months for children 24 months to 21 years of age.

¹² AAP Health Standards of Care for Foster Care Population: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx>

¹³ CWLA Standards of Excellence for Health Care Services for Children in Out of Home Care, Revised Edition, Child Welfare League of America, Inc., Washington, D.C., 2007.

¹⁴ AAP Health Standards of Care for Foster Care Population: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx>

II. Well-Being Visit Content

Each infant, child and adolescent should receive screening, assessment, monitoring and treatment/intervention through their medical home at every visit, including:

- Demographics;
- Health history, including: acute and chronic issues, nutrition, reproductive status, medications, allergies, immunizations, and any ongoing concerns for abuse or neglect;
- Physical health, including: growth parameters, hearing and vision, general physical health, oral/dental health, laboratory studies, and any signs of ongoing abuse or neglect;
- Development, including: gross motor, fine motor, sensory, and speech/language;
- Behavioral-emotional well-being;
- Traumatic experiences/exposure and trauma symptoms;
- Cognition and academic/vocational functioning;
- Social well-being, including: relationships, activities, and adjustment to placement and visitation;
- General child and caregiver training or service needs;
- Case management activities, including further referral, further evaluation and/or intervention.
- Permanency and safety support, as they relate to health and well-being.

III. Federal Requirements: Specific Screening, Assessment, Monitoring and Treatment

A. Oral Health Status

The NC foster care HOCP oral health protocol should integrate EPSDT requirements, as well as standards established by the AAP; the NC Institute of Medicine's Task Force on Children's Preventative Oral Health Services; the NC Oral Health Collaborative; the Division of Public Health's Oral Health Program; and Community Care of North Carolina's Oral Health Task Force whereby:

- A determination should be made upon entry into care as to whether a child has an existing dental home. All children should be assigned to a dental home by the time of their first dental eruption, and no later than one year of age.
- All children should participate in a dental assessment within 30 days of entry into foster care whereby:
 - Children under 3.5 years of age: Medical home personnel should conduct a dental history and screening using the CCNC Priority Oral Health Risk Assessment and Referral Tool (PORRT).¹⁵ Referrals to a pediatric or general dentist should be made based on the results of the PORRT.
 - Children over 3.5 years of age: Medical home personnel should refer older foster children to a dental provider for diagnostic examination.
- Children should continue to participate in preventive dental care every six months while in foster care, except when ongoing treatment needs or dental emergencies necessitate more frequent intervention. Specific recommendations include the following:
 - Children under 3.5 years of age should receive dental varnish applied by medical home personnel;
 - Children between 6 and 14 years of age should be evaluated for sealant need by their dental providers;
 - Children should be assessed for orthodontia and potential functional impairments at 2 years of age¹⁶; children and adolescents who may require orthodontia should be assessed for functional impairments by an orthodontic provider.

B. Developmental Status and Functioning

The NC foster care HOCP developmental health protocol should conform to EPSDT, IDEA, and CAPTA requirements, and should integrate AAP best-practice standards, whereby:

¹⁵Long CM, Quinonez RB, Beil HA, Close K, Myers LP, Vann WF Jr, Rozier RG. Pediatricians' assessments of caries risk and need for a dental evaluation in preschool aged children. BMC Pediatr. 2012 Jul 11;12:49. doi: 10.1186/1471-2431-12-49.

¹⁶According to the DMA Oral Health Periodicity Schedule, children should be "assessed for developing malocclusion beginning at age 2: <http://www.ncdhhs.gov/dma/dental/DentalPeriodicitySchedule11012011.pdf>

- Each child should participate in developmental screening upon entry into care, followed by a comprehensive assessment within 30 days;
- Each child should participate in ongoing developmental monitoring and assessment within their medical home, per an accelerated schedule established by the AAP;
- Children with developmental needs should be referred for further evaluation and/or for appropriate, effective intervention.

Developmental assessment should include: structured interviews with the child, parents, resource parents, caseworkers, and other professionals; the use of standardized developmental assessment measures; and/or review of the child's early intervention and/or educational progress.¹⁷

It is recommended that the following developmental domains be assessed at each well child visit: gross and fine motor skills; cognition; speech and language function; self-help abilities, and coping skills.¹⁸

C. Behavioral-Emotional Status and Functioning

The NC foster care HOCP behavioral-emotional health protocol should conform to EPSDT requirements, and integrate standards established by the AAP, whereby:

- Each child should participate in behavioral-emotional screening upon entry into foster care, followed by a comprehensive assessment within 30 days;
- Each child should participate in ongoing behavioral-emotional monitoring and assessment within their medical home, per an accelerated schedule established by the AAP;
- Screening and assessment for traumatic experience, exposure and/or symptoms should be conducted at each clinical encounter;
- Children with behavioral-emotional needs should be referred for further evaluation and/or for appropriate, effective intervention.

Behavioral-emotional assessment should include: structured interviews with the child, parents, resource parents, caseworkers, and other professionals;

¹⁷ American Academy of Pediatrics Committee on Early Childhood, Adoption, and Dependent Care. Health care of young children in foster care. *Pediatrics* 2002;109;536

¹⁸ American Academy of Pediatrics Committee on Early Childhood, Adoption and Dependent Care. Developmental issues for young children in foster care. *Pediatrics* 2000;106 (5): 1145 -1150

the use of standardized behavioral-developmental assessment measures; and/or review of the child's functioning across various environments.¹⁹

It is recommended that the following mental health domains be assessed at each well child visit: general behavior risk behaviors; trauma history and symptoms; and coping skills.

D. Educational Status and Functioning

The NC foster care HOCP educational status protocol should conform to EPSDT standards, and integrate AAP best-practice standards, whereby:

- Each child should participate in educational status screening upon entry into foster care.
- Each child should participate in ongoing monitoring and assessment of their educational status within their medical home, per an accelerated schedule established by the AAP;
- Children with educational needs should be referred for further evaluation and/or for appropriate, effective intervention.

Educational assessment should include: structured interviews with the child, parents, resource parents, caseworkers, and other professionals; the use of standardized developmental assessment measures; and/or review of the child's IEP/504 plan status and educational progress.²⁰

It is recommended that the following educational domains be assessed at each well child visit: school placement and attendance; academic achievement and difficulty; academic plans and interventions; and school behavior.

¹⁹ American Academy of Pediatrics Committee on Early Childhood, Adoption, and Dependent Care. Health care of young children in foster care. *Pediatrics* 2002;109:536

²⁰ Ibid.

Electronic Well-Being Passport

Per federal legislation, *Fostering Connections to Success and Increasing Adoptions Act of 2008*, the North Carolina foster care Health Oversight and Coordination Plan (HOCP) must include the following provision:

The state shall generate an electronic health record for each infant, child and adolescent, upon entry to foster care, including critical medical information that is routinely updated and shared per standardized protocols.

It is recommended that a data exchange platform be developed to support the health and well-being of the North Carolina foster care population. The platform should integrate existing administrative and clinical databases, to create: i) an electronic 'well-being passport' for each foster child and ii) an aggregate foster care data repository. Further, it should meet all state and federal confidentiality and security requirements, and integrate standards established by the AAP²¹ and the CWLA²². Overall, the foster care data exchange should support the following key functions and activities:

- Population health and well-being oversight and coordination;
- Individual health and well-being oversight and coordination, specifically supporting case management activities, clinical care, educational/vocational support, and transition planning;
- Communication, care coordination and consultation across state leadership, state program and entities, agencies, clinicians, families, and foster youth;
- Documentation of clinical conclusions and interventions;
- Medication oversight and management.

²¹ AAP Health Standards of Care for Foster Care Population: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx>; ²¹ American Academy of Pediatrics, *Fostering Health: Health Care for Children and Adolescents in Foster Care, 2nd Edition*, 2005.

²² CWLA Standards of Excellence for Health Care Services for Children in Out of Home Care, Revised Edition, Child Welfare League of America, Inc., Washington, D.C., 2007.

Medical Home Network

Per federal legislation, *Fostering Connections to Success and Increasing Adoptions Act of 2008*, the North Carolina foster care Health Oversight and Coordination Plan (HOCP) includes the following provision:

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, benefit from comprehensive care through a network of medical homes that meets accepted standards, assuring continuity of health care standards.

It is recommended that a multi-tiered medical home network be developed to support the well-being of the North Carolina foster care population. The **medical home** is an approach to providing comprehensive, coordinated care to children with special health care needs. The American Academy of Pediatrics has established standards whereby the medical home is required to²³:

- Provide family-centered care;
- Share clear and unbiased information with the family about the child's medical care and management;
- Provide primary care services, addressing acute and chronic care, as well as preventive, services;
- Ensure continuous access to emergency and/or inpatient care;
- Support effective transition across care providers and services;
- Identify of the need for consultation and appropriate referral to pediatric medical subspecialists and surgical specialists;
- Coordinate with intervention programs, schools, early childhood education and child care programs, and other public and private community agencies to be certain that the special needs of the child and family are addressed;
- Provide care coordination services in which the family, the physician, and other service providers work to implement a specific care plan as an organized team.
- Maintain an accessible, comprehensive, central record that contains all pertinent information about the child, preserving confidentiality.

Per AAP Standards, the medical home network is:

- ✓ *Accessible*
- ✓ *Family-centered*
- ✓ *Comprehensive*
- ✓ *Coordinated*
- ✓ *Continuous*
- ✓ *Compassionate*
- ✓ *Culturally - competent*

²³Pediatrics Vol. 110 No. 1 July 1, 2002, pp. 184 -186

Consideration should be given to establishing a service delivery platform for foster children that includes:

- *Community-based medical homes* that adhere to AAP medical home standards, and meet performance criteria as established by a reputable accrediting body;
- *Regional centers of excellence* that adhere to AAP medical home standards; participate in continuous quality improvement efforts; and provide clinical and implementation support to community-based medical homes, local department of social services, and other stakeholders.
- *Sub-specialty care referral network* that includes the following consultants and therapists:
 - a. *Health specialists addressing:*
 - Primary care and medical sub-specialties
 - Oral health
 - Development
 - Pharmacology
 - Ancillary services
 - b. *Mental health specialists addressing:*
 - Psychotherapy, psychology, psychiatry, and neuropsychology
 - Substance abuse
 - Psychopharmacology
 - c. *Educational specialists addressing:*
 - General educational
 - Early education

Prescription Medication Oversight

Per federal legislation, *Fostering Connections to Success and Increasing Adoptions Act of 2008*, the North Carolina foster care Health Oversight and Coordination Plan (HOCP) must include the following provision:

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, benefit from oversight of prescription medication use, including appropriate use and monitoring of psychotropic medication.

It is recommended that a prescription medication oversight protocol be established to support the health and well-being of the North Carolina foster care population whereby:

- Prescription utilization data is collected, monitored, and analyzed;
- Policies and protocols are continuously monitoring and adjusted to support the safe and effective use of prescription medications, specifically addressing prescribing practices; storage and administration; and the establishment of informed consent policies;
- Curricula and materials are developed to support the safe and effective use of prescription medication;
- State agencies, clinicians, system of care professionals, families, and youth are able to consult with experts regarding the safe and effective use of prescription medication, both at the individual and population level.

Proposed Guidelines for the Oversight and Management of Psychotropic Medication

It is recommended that a protocol be developed to ensure appropriate use and monitoring of psychotropic medication across the North Carolina foster care population. This protocol should be based upon standards established by: the American Academy of Child and Adolescent Psychiatry (AACAP)²⁴, the Michigan Department of Human Services Health Oversight and Coordination Plan (2011)²⁵, the Child Welfare League of America²⁶, the American Academy of Pediatrics(Committee on Early Childhood, Dependent et al. 2002, Crismon and Argo 2009)²⁷, and the Texas Psychotropic Medication Utilization Parameters for Foster Children Workgroup.²⁸ Further, the protocol should incorporate system and clinical standards, as follows:

Systems-Level Protocol Requirements²⁹

- Comprehensive and coordinated screening, assessment*, and treatment planning mechanisms to identify and address mental health needs; this includes psychiatric evaluation, as necessary, to identify need for psychotropic medication;

*Qualified, licensed mental health providers should conduct comprehensive assessments, using evidence based screening or assessment instruments that have been shown to be valid and reliable within the child welfare system.

- Expert consultation availability regarding psychotropic medication use, addressing clinical issues, consent, and monitoring at the population and individual levels, with expertise provided by a board-certified or board-eligible Child and Adolescent Psychiatrist;
- Expert monitoring of psychotropic medication utilization practice, with consideration to expanding upon principles of the existing A+ KIDS registry³⁰ which currently tracks:
 - Antipsychotic prescription for an indication that is not approved by the federal Food and Drug Administration.

²⁴ Issues, A.C.o.Q., *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents*. Journal of the American Academy of Child and Adolescent Psychiatry, 2009. **48**(9): p. 961-973.

²⁵ (MDHS), T.M.D.o.H.S., *The Michigan Department of Human Services (MDHS) Health Oversight and Coordination Plan*, 2011.

²⁶ Jensen, P.J., Hunter Romanelli, L., Pecora, P. J., & Ortiz, A., *MENTAL HEALTH PRACTICE GUIDELINES FOR CHILD WELFARE*. Child Welfare, 2009. **88**(1).

²⁷ Committee on Early Childhood, A., C. Dependent, and P. American Academy of, *Health care of young children in foster care*. Pediatrics, 2002. **109**(3): p. 536-41.

²⁸ Services, T.D.o.F.a.P., and, and T.U.o.T.a.A.C.o. Pharmacy, *Psychotropic Medication Utilization Parameters for Foster Children* 2010. p. 19.

²⁹ Care, A.C.o.C.-B.S.o., *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents*, 2012, American Academy of Child & Adolescent Psychiatry.

³⁰Carolina, C.C.o.N., *A+Kids -Promoting safe and effective use of antipsychotic agents in children*, 2011.

- Antipsychotic prescription at a dosage that is higher than currently approved for an indication per the federal Food and Drug Administration.
- A prescribed antipsychotic that will result in the concomitant use of two or more antipsychotic agents.
- Mechanism for exchanging information, and engaging in informed, shared decision-making strategies between the psychotropic medication prescriber, the child, caregivers, and other healthcare providers, and stakeholders;
- Mechanisms for exchanging information between state policy makers, division leadership, system of care professionals, clinicians, and other stakeholders regarding psychotropic medication, including service needs, capacity, utilization, and cost.

Clinical-Level Protocol Requirements

- Prior to prescribing psychotropic medication:
 - A DSM-5 psychiatric diagnosis should be made;
 - A trial of evidence-based psychosocial treatment should be pursued for treatment of mild to moderate illness;
 - Clearly defined target symptoms and treatment goals* for the use of psychotropic medications should be identified and documented in the medical record at the time of or before beginning treatment with a psychotropic medication.

*Target symptoms and treatment goals should be assessed at each clinical visit with the child and caregiver. Whenever possible, recognized clinical rating scales or other measures should be used to quantify the response of the child's target symptoms to treatment and the progress made toward treatment goals;

- Consideration should be given to potential side effects, including those that are uncommon but potentially severe, and evaluating the overall benefit-to-risk of pharmacotherapy. The clinician should also take into consideration birth control status, potential for pregnancy, and other potentially complicating medical conditions or medications.
- Informed consent* should be obtained from the appropriate party(s) before beginning psychotropic medication.

*Informed consent to treatment with psychotropic medication includes: diagnosis; expected benefits and risks of treatment, including common side effects, as well as potentially life-threatening effects; and discussion of laboratory findings. Alternative treatments, and the risk associated with no treatment, should be discussed.

- Psychotropic medication prescription principles are as follows:
 - Psychotropic medication use should be combined with evidence-based psychosocial treatment under most circumstances;
 - Monotherapy (single medication) regimens for a given disorder or specific symptoms should usually be prescribed prior to prescribing polypharmacy (multiple medications) regimens;
 - Treatment should usually incorporate low dose medication, titrating (increasing or decreasing) dosage as necessary to achieve clinical goals;
 - Only one psychotropic medication should be introduced at a time, unless a specific clinical reason to start two or more medications can be clearly documented;
 - Before adding additional psychotropic medications to a regimen, children should be assessed for adequate medication adherence, accuracy of the diagnosis, the occurrence of co-morbid disorders, and the influence of psychosocial stressors;

If the prescribing clinician is not a child psychiatrist, referral to or consultation with a psychiatrist should occur if the child's clinical status has not experienced meaningful improvement within a timeframe that is appropriate for the child's clinical status and the medication regimen.

- When medication changes are warranted within the same class of psychotropic medications, a 60 day cross-over period (titration of the new agent and taper of the agent to be discontinued) is indicated, unless the agent to be discontinued is causing adverse effects;
- If psychotropic medication is prescribed to manage aggression associated with a DSM-5 non-psychotic diagnosis (conduct disorder, oppositional defiant disorder, and/or intermittent explosive disorder), necessity for continued treatment should be evaluated at a minimum of every six months. If the behavior disturbance is in remission for six months, consideration should be given to slow tapering and discontinuation;

- Monitoring and Documentation Strategies
 - The frequency of clinician follow-up with the patient should be appropriate for the severity of the child’s condition and adequate to monitor response to treatment, including: symptoms, behavior, function, and potential medication side effects.
 - In depressed children and adolescents, the potential for suicidality should be routinely monitored and evaluated.
 - The clinician should clearly document the following in the medical record: clinical history; mental status assessment; physical indices; physical findings; clinical impression; treatment plan; psychotropic medication name, dose, and indication; laboratory monitoring indices specific to the psychotropic medication, at clinically-appropriate intervals; medication response, and presence or absence of side effects.

Special Needs of Preschool-Age Children

It is recommended that the NC Foster Care Psychotropic Medication protocol specifically address the use of psychotropic medication among preschool-age children, incorporating standards established by the AACAP Preschool Psychopharmacology Working Group.³¹ Specifically, preschool guidelines should address the special needs and requirements of this vulnerable population, including:

- Age-appropriate assessment and psychiatric diagnostic methodology;
- Impact of psychotropic medication on neuro-developmental;
- Regulation and ethics of psychotropic medication use (including available safety information and FDA status);
- Evidence supporting efficacy and safety of psychotropic medication use;
- Emphasis on non-psychopharmacological interventions, including a 12-week trial of non-psychopharmacological intervention;
- Parental mental health needs and functioning.

³¹ Psychopharmacological Treatment for Very Young Children: Contexts and Guidelines, *J. Am. Acad. Child Adolesc Psychiatry*, 46:12, December 2007.

Clinical Cases Requiring Further Review

It is recommended that the NC Foster Care Psychotropic Medication protocol include guidelines whereby specific clinical and/or utilization factors trigger more detailed oversight and review. It is further recommended that this protocol incorporate standards outlined in the Texas Psychotropic Medication Utilization Parameters for Foster Children and updated in The Michigan Department of Human Services (MDHS) Health Oversight and Coordination Plan³², whereby the following factors trigger expert case review:

- Absence of a thorough assessment and/or DSM-5 diagnosis in the medical record;
- Psychotropic medications are prescribed for children under six years of age;
- A prescribing pattern that includes:
 - Medication use that is not consistent with the patient's psychiatric diagnosis and/or target symptoms;
 - Reliance on polypharmacy without a trial of psychotropic monotherapy;
 - Four or more psychotropic medications prescribed and/or used concomitantly,
 - Two or more concomitant antidepressants, antipsychotic medications, or stimulant medications, mood stabilizers
 - Psychotropic medication dose exceeding the usually recommended dose.

³² (MDHS), T. M. D. o. H. S. (2011). The Michigan Department of Human Services (MDHS) Health Oversight and Coordination Plan.

Well-Being Consultation Protocol

Per federal legislation, *Fostering Connections to Success and Increasing Adoptions Act of 2008*, the North Carolina foster care Health Oversight and Coordination Plan (HOCP) must include the following provision:

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, benefit from health and well-being oversight through a consultation protocol established between NC DSS, NC DMA, CCNC, local departments of social service, other state entities, physicians and well-being experts.

It is recommended that a protocol be established whereby youth, biological families, resource parents, system of care professionals, state leadership, and medical home personnel might consult with foster care health and well-being experts. Specifically, it is recommended that the NC HOCP consultation protocol support:

- Individual-level referrals for evaluation and/or intervention through well-being experts and sub-specialists;
- Telephone and web-based consultation, addressing individual- and population- level:
 - Clinical queries,
 - Service and resource queries,
 - Curriculum and training requests,
 - Policy and programming support request;
- State-level monitoring of consultation queries and requests, as well as service need deficits.

Educational Stability

Per federal legislation, the *Fostering Connections to Success and Increasing Adoptions Act of 2008*, the North Carolina foster care Health Oversight and Coordination Plan (HOCP) includes the following provision:

The state shall ensure that each child and adolescent will, upon entry into foster care, benefit from an individual service plan that specifically assures educational stability, and provides educational and vocational coordination and support.

It is recommended that protocol be established whereby local county departments of social services (DSS) develop individual service plans addressing educational stability, coordination, and support for all children and youth entering foster care. This protocol should conform to all federal mandates, including the Uninterrupted Scholars Act³³, and conform to all best practice standards, mandating DSS to:

- Identify a child's school placement upon entry into foster care; attempt to support the current school placement, immediately enrolling the child in a new school if a change is necessary and/or unavoidable;
- Review and update the educational record each time a child or youth enters foster care, providing a copy to the resource parents;
- Develop a written case plan that addresses: school contact information, grade level; academic history; academic plan and supports (IEP/504 plan); and other key educational information;
- Monitor school attendance and progress;
- Provide a copy of the updated educational record to the family and/or youth when the child exits foster care.

³³ Affordable Care Act of 2010 (P.L. 111-148)

Transitional Plan for Youth Aging-Out of Foster Care

Per federal legislation, *Fostering Connections to Success and Increasing Adoptions Act of 2008*, the North Carolina foster care Health Oversight and Coordination Plan (HOCP) includes the following provision:

The state shall ensure that each adolescent will, upon entry into foster care, benefit from a transition plan that assures they will receive information addressing: health insurance options; health care powers of attorney; and health care proxies.

It is recommended that local department of social services (DSS) staff assist youth who are aging out of foster in developing a transition plan that addresses:

- Health insurance options for those youth aging-out of care at 18 years of age, whereby the Affordable Care Act allows foster youth who were receiving Medicaid at age 18, to receive Medicaid benefits until 26 years of age³⁴;
- Establishment of a health care power of attorney;
- Establishment of health care proxies.

³⁴ The state is currently planning for the implementation of the Affordable Care Act of 2010 (P.L. 111-148) provision that takes effect January 1 2014, allowing all former foster care children who aged out of care at 18, and were receiving Medicaid at age 18, to receive Medicaid until age 26.

Section II: Recommended Infrastructure to Support Implementation of the North Carolina Health Oversight and Coordination Plan

Foster children demonstrate disproportionately high rates of dysfunction compared to the general child population. Furthermore, they incur greater health care costs compared to age-matched peers enrolled in state Medicaid programs.^{35 36} Federal legislation attempts to address these disparities in health care status and cost. Specifically, the *Fostering Connections to Success and Increasing Adoptions Act of 2008* requires states to develop a Foster Care Health Oversight and Coordination Plan (HOCP) under the leadership of the Division of Social Services (NC DSS), the Division of Medical Assistance (NC DMA), and medical experts.³⁷ The HOCP must ensure a coordinated strategy to identify and respond to the health care needs of children in foster care, including mental health and dental health needs.

In order to meet *Fostering Connections* requirements, Section 1 proposes a Health Oversight and Coordination Plan (HOCP). The current section, Section II, describes a recommended infrastructure to implement and sustain the HOCP. Referred to as the ***Fostering Well-Being Program*** throughout this section, it is recommended that the HOCP implementation platform include the following core components:

- ***Fostering Well-Being*** staff embedded within a designated health services management entity (**ME**), partnering with experts in the fields of child welfare, health, oral health, development, mental health and education;

Options for a designated, statewide foster care health services management entity (**ME**) include:

- Community Care of North Carolina (**CCNC**) and/or,
- A single Community Care Entity (**CCE**) authorized to manage the foster care population, through the *Partnership for a Healthy North Carolina*.

³⁵ Center for Health Care Strategies (2008). Medicaid Managed Care for Children in Child Welfare. Issue Brief. Accessed at http://www.chcs.org/usr_doc/CW_MC_Brief.pdf.

³⁶ Data from a NC Pediatric Society pilot program at Wilmington Health indicate that the health care costs of fostered children are about 9 times the cost (per member per month) as non-fostered children in the Medicaid population.

³⁷ *Fostering Connections to Success and Increasing Adoptions Act of 2008* (P.L. 110-351)

- Dedicated policy advisors from key state agencies, supported by state leadership;
- An electronic Well-Being Passport for each child foster care, and a central population-level data repository called the *Fostering Well-Being* Database;
- Execution of core public health functions through the *Fostering Well-Being* platform and a trained workforce;
- Development and support of a medical home network, including community-based practices and, regional centers of excellence;
- Development, coordination and support of a health and well-being services array;
- Adoption and ongoing modification of a federally-mandated North Carolina Foster Care Health Oversight and Coordination Plan (HOCP).

Proposed Leadership, Staff and Team Composition:

- ✓ ***Central Health Services Management Team***
- ✓ ***Expert Advisory Panel***
- ✓ ***Regional Health Services Management Teams***
- ✓ ***Medical Home Network***

Section 2.1 Dedicated Staff and Expert Consultants

Successful implementation of North Carolina Foster Care HOCP requires dedicated staff and expert consultants charged with implementing and supporting HOCP strategies. A cornerstone of the proposed North Carolina *Fostering Well-Being* program is a five-tier health oversight and coordination infrastructure that includes:

- A central *Fostering Well-Being* health services management team (**Management Team**) embedded within the designated management entity (**ME**), coordinating with designated state policy liaisons;

Options for a designated, statewide foster care health services management entity (**ME**) include:

- Community Care of North Carolina (**CCNC**) and/or,
 - A single Community Care Entity (**CCE**) authorized to manage the foster care population, through the *Partnership for a Healthy North Carolina*.
- A *Fostering Well-Being* expert clinical advisory panel (**Advisory Panel**);
 - Regional *Fostering Well-Being* health services management teams (**Regional Teams**), embedded within the designated ME network;
 - A network of regional and community-based medical homes, as well as a specialized referral network, addressing physical, oral, developmental, behavioral-emotional, educational, and social health and well-being (**Medical Home Network**).

Proposed Staff and Consultant Array

I. *Fostering Well-Being* Central Health Services Management Team

It is recommended that a *Fostering Well-Being* Management Team be established within the designated ME to:

- Provide budgetary and general program management and oversight;
- Develop and manage a *Fostering Well-Being* database and Well-Being Passport program [see below];

- Develop and coordinate a *Fostering Well-Being* Advisory Panel, providing expert clinical consultation, as well as oversight and coordination of well-being services across the foster care population;
- Develop and coordinate regional *Fostering Well-Being* health services management teams (Regional Teams) through the designated ME network, including development of strategies to provide individual-level medical management;
- Develop a network of foster care medical homes across North Carolina, including: community-based practices, regional centers of excellence, and a specialty referral network.

It is recommended that a dedicated *Fostering Well-Being* Management Team include the following staff:

a. NC DSS and NC DMA policy liaisons

It is recommended that NC DSS and NC DMA designate liaisons to the *Fostering Well-Being* program in order to:

- Serve as policy liaisons between their respective agencies and: the designated ME, *Fostering Well-Being* staff, expert Advisory Panel, regional health services management teams, the medical home network, local departments of social services (**DSS**), regional mental health managed care organizations (**MCOs**), and other stakeholders;
- Provide *Fostering Well-Being* program oversight and cross-systems coordination;
- Guide the *Fostering Well-Being* program in developing appropriate policy and procedures to assure safety, permanency, and optimal health and well-being across the foster care population.

b. *Fostering Well-Being* Program Director

It is recommended that there is a *Fostering Well-Being* Program Director to: oversee the development and implementation of the *Fostering Well-Being* program, in full compliance with state and federal requirements; coordinate program strategies and activities with state leadership and entities; ensure that foster care health and well-being goals are met; and oversee *Fostering Well-Being* personnel, including, for example:

- Medical, Oral Health and Mental Health Directors;

- Case Management Director;
- *Fostering Well-Being* Database Director;
- Informatics Director and data entry support staff;
- General administrative support.

II. ***Fostering Well-Being* Expert Advisory Panel**

It is recommended that NC DSS and NC DMA establish a *Fostering Well-Being* Advisory Panel to:

- Support the development of health oversight and coordination strategies across the North Carolina foster care population;
- Support the development of the *Fostering Well-Being* database and Well-Being Passport program;
- Analyze individual and population level health and well-being data collected through the *Fostering Well-Being* database;
- Provide expert clinical support and technical assistance at the individual and population level;
- Assist in the development and support of a network of foster care medical homes across North Carolina;

It is recommended that the *Fostering Well-Being* Advisory Team include the following:

d. *Health Specialists*

- Primary care providers and medical subspecialists;
- Adolescent and reproductive health specialists;
- Oral health specialists;
- Developmental and early intervention specialists;
- Pharmacologists.

e. *Mental Health Specialists*

- Psychotherapists, psychologists, psychiatrists, and neuropsychologists;
- Substance abuse specialists;
- Psychopharmacologists;
- Ancillary service providers and therapists addressing: physical, occupational, developmental, and hearing/speech/language well-being.

- f. *Educational Specialists*
 - General educational specialists;
 - Early education specialists.

- g. *Systems and Other Key Stakeholders*
 - NC DHHS, NC DPI, and NC DPS divisional leadership and staff;
 - MCO leadership and staff;
 - ME central and regional leadership and staff;
 - NC Child Treatment Program representation;
 - NC Pediatric Society representation;
 - Tribal affairs representation.

III. **Regional *Fostering Well-Being* Health Services Management Teams**

It is recommended that NC DSS and NC DMA establish regional *Fostering Well-Being* health services management teams (Regional Teams) within the designated ME network, to be coordinated and managed by the designated ME and the *Fostering Well-Being* Management Team. The Regional Teams would:

- Assist in the development of health oversight and coordination strategies across the North Carolina foster care population;
- Assist in the development of the proposed *Fostering Well-Being* database and Well-Being Passport program;
- Participate in individual-level well-being data collection;
- Provide support in the analysis of individual and regional level well-being data;
- Provide expert clinical support and technical assistance at the individual and regional level;
- Assist in the development and support of foster care medical homes in the region;
- Provide individual-level health and well-being management for foster children living in the region;
- Assist *Fostering Well-Being* staff in executing core public health functions across the foster care population.

It is recommended that the *Fostering Well-Being* Regional Teams include:

- a. *Local and Regional Health Specialists*
 - Primary care providers and medical subspecialists;
 - Adolescent and reproductive health specialists;

- Oral health specialists;
 - Development and early intervention specialists;
 - Pharmacologists.
- b. Local and Regional Mental Health Specialists*
- Psychotherapists, psychologists, psychiatrists, and neuropsychologists;
 - Substance abuse specialists;
 - Psycho-pharmacologists;
 - Ancillary service providers and therapists addressing:, physical, occupational, developmental, and hearing/speech/language well-being.
- c. Local and Regional Education Representatives*
- General educational specialists;
 - Early education specialists.
- d. Local and Regional Stakeholders*
- Local Departments of Social Services;
 - Local Departments of Public Health;
 - Local school districts and educational boards;
 - Local MCO leadership and staff;
 - Local ME regional leadership and staff;
 - NC Child Treatment Program representation;
 - NC Pediatric Society representation;
 - Tribal affairs representation;
 - Resource Parents.

IV. Medical Home Providers and Staff

See Medical Home Personnel and Staff below.

Section 2.2 Well-Being Passport Program and Foster Care Well-Being Database

Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L.110-351) requires states to develop a mechanism for health information exchange, using an electronic health record and standardized protocols. The Child Welfare League of America (CWLA) similarly endorses the use of an abbreviated health record. Per CWLA best practice standards, this record should be available to authorized clinicians caring for foster children, and should contain critical health and well-being information, while flagging identified health risks.³⁸ It is recommended that the following infrastructure supports be developed and sustained through the *Fostering Well-Being* program:

- An electronic **Well-Being Passport** program, tracking individual health and well-being parameters for each child in the North Carolina foster care system;
- A **Fostering Well-Being Database**, a repository of data collected through the Well-Being Passport program, and maintained by a designated ME.

Data collected and analyzed through the Well-Being Passport program and *Fostering Well-Being* Database initiative would support the following strategies:

- Population health and well-being oversight and coordination;
- Individual health and well-being oversight and coordination, supporting case management activities, clinical care, educational/vocational support, and transitional planning;
- Communication, care coordination and consultation across state leadership, state program and entities, agencies, clinicians, families and foster youth;
- Documentation of clinical conclusions and interventions

Fostering Well-Being Data Management Elements

- ✓ **Well-Being Passport:** Electronic record of individual health and well-being parameters
- ✓ **Fostering Well-Being Database:** Repository of data collected through individual Well-Being Passports

³⁸ Child Welfare League of America. (2007). *Standards of excellence for health care services for children in out-of-home care; revised edition*. Washington, DC.

including assessment findings and interventions, to avoid duplication and provider error;

- Medication oversight and management.

I. Proposed Data Exchange Administrative Home and Data Sources

It is recommended that the state develop a *Fostering Well-Being* Database and Well-Being Passport program through the designated management entity (**ME**). As the administrative home for the *Fostering Well-Being* program, the designated ME must have an informatics system capable of supporting individual and population-level well-being data exchange through the NC Health Information Exchange. Optional platforms for *Fostering Well-Being* data exchange include the CCNC Informatics Center and/or a CCE-managed data system.

The *Fostering Well-Being* database and the individual Well-Being Passports should be populated through authorized data exchange with:

- Medicaid paid claims data;
- Hospital admissions and discharge data;
- A+ KIDS Registry data;
- Immunization records;
- Personal health records, as authorized;
- NC Child Treatment Program data;
- NC FAST and NC Tracks data;
- Other NC DHHS, NC DPI and NC DPS well-being data.

II. Well-Being Passport and Well-Being Database Elements

It is recommended that designated ME and state leadership, *Fostering Well-Being* staff, and members of the Advisory Panel identify those data elements necessary to support health care oversight and coordination at the population-level, while facilitating excellent care management at the individual-level. Per CWLA standards³⁹, the following data elements should be routinely collected, exchanged, aggregated and analyzed:

- a. Child demographics
- b. Health history and health status

³⁹ Child Welfare League of America. (2007). *Standards of excellence for health care services for children in out-of-home care; revised edition*. Washington, DC.

- Medication and drug allergies;
 - Laboratory, radiologic and special studies;
 - Treatment and intervention.
- c. Oral Health
- History and oral health status;
 - Fluoride varnish and sealant status;
 - Treatment and intervention.
- d. Development
- History and developmental status;
 - Treatment and intervention.
- e. Mental Health
- History and mental health status;
 - Psychotropic medication;
 - Therapeutic placements, treatment, and intervention.
- f. Educational Well-Being
- Enrollment, attendance, promotion/retention and graduation status;
 - Academic and cognitive testing results;
 - Special needs plans, accommodations, and interventions.
- g. Care Management and Coordination
- Integrated care plan, including DSS LINKS and CARS plans;
 - “Flagged” well-being parameters, indicating the need for further evaluation and/or intervention.
- h. Population and Program Implementation Data
- Service needs, access, and satisfaction;
 - Workforce and service capacity;
 - Service utilization and cost;
 - Intervention fidelity and clinician competency;
 - Program implementation benchmarks;
 - Clinical outcomes.

III. Data Collection, Exchange, Aggregation and Analysis

It is recommended that *Fostering Well-Being* staff, ME staff, and experts will design a protocol for the collection, exchange, aggregation, and analysis of critical foster care health and well-being data. Specifically, a Well-Being Passport will be generated for each child upon entry into care, and populated through existing databases. Ongoing data entry will be conducted by authorized professionals, during routine interactions with foster children.

Individual level well-being data, as well as health and administrative data, will form the basis of the population-level *Fostering Well-Being* Database. Designated ME staff, *Fostering Well-Being* staff, and members of the expert Advisory Panel will analyze data, focusing on assurance of optimal health and well-being across the population, in the most cost-effective manner. Data and analysis will be shared with state leadership, and other stakeholders, on a routine basis.

IV. Data Access, Security and Confidentiality

Secure access to individual Well-Being Passports and to the *Fostering Well-Being* Database will be authorized per criteria established by state leadership and staff, designated ME staff, and *Fostering Well-Being* staff. Specifically, limited access will be authorized to those professionals directly involved in service delivery, care coordination, and/or care oversight. Additionally, biological parents and resource parents will be granted access to health information pertaining to a foster child in their care. Finally, foster youth and alumni will have access to their own health and well-being information through an electronic portal.

Access to secure, authorized health and well-being data will conform to all federal and state requirements, including those mandated through the Health Information Privacy and Portability Act (HIPPA) and the Family Educational Rights and Privacy Act (FERPA).

Section 2.3 Medical Home Network

Per federal legislation, *Fostering Connections to Success and Increasing Adoptions Act of 2008*, the North Carolina foster care Health Oversight and Coordination Plan (HOCP) includes the following provision:

The state shall ensure that each infant, child and adolescent will, upon entry into foster care, benefit from comprehensive care through a network of medical homes that meets accepted standards, assuring continuity of health care standards.

The Medical Home is an approach to providing primary care that is characterized by the American Academy of Pediatrics (AAP) as having these core components: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.⁴⁰ For more information about the value of a medical home for children in care (with Special Health Care Needs), see Section III. The AAP further recommends that the medical home provide the following services employing standards found throughout this Health Oversight and Coordination Plan:

1. Provision of family-centered care through developing a trusting partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life.
2. Sharing clear and unbiased information with the family about the child's medical care and management and about the specialty and community services and organizations they can access.
3. Provision of primary care, including but not restricted to acute and chronic care and preventive services, including breastfeeding promotion and management,⁷ immunizations, growth and developmental assessments, appropriate screenings, health care supervision, and patient and parent counseling about health, nutrition, safety, parenting, and psychosocial issues.
4. Assurance that ambulatory and inpatient care for acute illnesses will be continuously available (24 hours a day, 7 days a week, 52 weeks a year).
5. Provision of care over an extended period of time to ensure continuity. Transitions, including those to other pediatric providers or into the adult health care system, should be planned and organized with the child and family.

⁴⁰ <http://pediatrics.aappublications.org/content/110/1/184.full?sid=41c23135-7e32-4fab-9dc8-384aa209f242#ref-2>

6. Identification of the need for consultation and appropriate referral to pediatric medical subspecialists and surgical specialists. (In instances in which the child enters the medical system through a specialty clinic, identification of the need for primary pediatric consultation and referral is appropriate.) Primary, pediatric medical subspecialty, and surgical specialty care providers should collaborate to establish shared management plans in partnership with the child and family and to formulate a clear articulation of each other's role.
7. Interaction with early intervention programs, schools, early childhood education and child care programs, and other public and private community agencies to be certain that the special needs of the child and family are addressed.
8. Provision of care coordination services in which the family, the physician, and other service providers work to implement a specific care plan as an organized team.
9. Maintenance of an accessible, comprehensive, central record that contains all pertinent information about the child, preserving confidentiality.
10. Provision of developmentally appropriate and culturally competent health assessments and counseling to ensure successful transition to adult-oriented health care, work, and independence in a deliberate, coordinated way.

Protocol should be developed that creates a multi-tiered system for a statewide medical home network for the foster care population. Tiers should include the following:

- *Community-based medical homes* that adhere to AAP medical home standards, and meet performance criteria as established by a reputable accrediting body and as described in Section II of this document.
- *Regional centers of excellence* that meet AAP medical home standards; participate in continuous quality improvement efforts; and provide consultative support and technical assistance to community-based medical homes, local department of social services, and other stakeholders.
- *A Sub-specialty care referral network* that includes the following consultants and therapists:
 - h. *Health specialists addressing:*
 - Primary care and medical sub-specialties
 - Adolescent and reproductive health
 - Oral health
 - Development
 - Pharmacology

- i. Mental health specialists addressing:*
 - Psychotherapy, psychology, psychiatry, and neuropsychology
 - Substance abuse
 - Psychopharmacology
 - Ancillary services (physical therapy; occupational therapy, developmental therapy, and hearing/speech/language)

- j. Educational specialists addressing:*
 - General educational
 - Early education

Section 2.4 Infrastructure Supports and Resources

Successful implementation of the NC Foster Care HOCP requires the development of core infrastructure components, including: dedicated staff and expert consultants; an electronic Well-Being Passport for each foster child; a statewide *Fostering Well-Being* Database; and a network of medical homes and a referral base. Other critical infrastructure supports and resources include: program authorization and leadership; stakeholder engagement; development of a competent workforce; and engagement with support organizations and programs as follows:

I. Program Authorization and Leadership

To meet federal *Adoption and Safe Families Act of 1997* and *Fostering Connections to Success and Increasing Adoptions Act of 2008* requirements, the state must develop and implement a statewide foster care HOCP.

NC DSS and NC DMA are required to develop and sustain a state foster care HOCP. Additionally, the Partnership for a Healthy North Carolina and/or Community Care of North Carolina (CCNC) may also have a central role in successful HOCP implementation. Specifically:

- **North Carolina Division of Social Services (NC DSS)**⁴¹, a division of the NC Department of Health and Human Services, provides oversight, training, technical assistance, and consultation to the 100 local departments of social services (DSS). NC DSS is charged with developing health and well-being policies and procedures, in response to federal and state legislation, and in response to emerging population needs.
- **North Carolina Division of Medical Assistance (NC DMA)**⁴², a division of the NC Department of Health and Human Services, manages the state's Medicaid program, ensuring that foster children have access to: high-quality, medically-necessary health care; case management; and other related entitlement services.

Fostering Well-Being Platform: Infrastructure Supports and Resources

- ✓ *Program authorization and leadership*
- ✓ *Stakeholders and state agencies*
- ✓ *Competent workforce*
- ✓ *Support organizations and programs*

⁴¹ Add website

⁴² Add website

- ***Partnership for a Healthy North Carolina*** is a Medicaid reform framework introduced by state leadership in April of 2013. The Partnership is an implementation platform for the delivery of high-quality, cost-effective, health care services managed through the selection of multiple statewide management entities, or Comprehensive Care Entities (CCEs). The proposed CCEs will develop a service provider network, as well as help determine the most effective course of treatment for each child participating in the state Medicaid program.
- ***Community Care of North Carolina (CCNC)***⁴³ is a statewide, non-profit managed care organization that delivers high-quality, cost-effective medical services to the Medicaid population through fourteen regional networks. Foster children are automatically enrolled in a CCNC medical home, and receive comprehensive care as well as case management services, unless the family and/or local DSS elect to opt out. Note: CCNC in partnership with the Division of Public Health have developed a program addressing the special needs of children between birth and five years of age, *Care Coordination for Children (CC4C)*.

The CCNC Informatics Center (CCNC IC) is an electronic data exchange infrastructure, populated by state administrative databases, including⁴⁴:

- Health care claims data provided by Medicaid;
- Laboratory data (Lab Corps);
- Hospital admissions and discharge data;
- A+ KIDS Registry data;
- Immunization records;
- Health information obtained directly from health care providers, care managers and primary care medical records.

Currently, CCNC IC data is accessed by authorized network staff and health care professionals to: identify patients in need of care coordination; facilitate disease management, population management, and pharmacy management initiatives; enable communication of key health information across settings of care; monitor cost and utilization

⁴³ Add website

⁴⁴ Add reference and/or website

outcomes; and to monitor quality of care and provide performance feedback at the patient, practice, and network level. CCNC is collaborating with the North Carolina Health Information Exchange to improve access to health care data and electronic medical records across authorized health care professionals.⁴⁵

II. Stakeholders

Successful implementation of *Fostering Well-Being* and the NC Foster Care HOCP requires the direct support of, and coordination with, public and private stakeholders at state and local levels, including:

- ***Parents, Resource Parents and Residential Staff*** provide and/or oversee the daily care of children in foster care, and include: biological and adoptive parents, guardians, licensed foster parents, licensed kin, and residential staff. Specifically, they are responsible for providing a safe, stable living environment for each child in care. Additionally, they are critical in the prevention, early identification, assessment, and treatment of health and well-being problems across the population.
- ***Local Departments of Social Services (DSS)*** are charged with ensuring safety, permanency, and optimal health and well-being of the foster population. Specifically, staff from the 100 local DSS offices must ensure that each foster child is enrolled in the state’s Medicaid program and in a community-based medical home.
- ***Guardian ad Litem (GAL) Program***⁴⁶, a program offered through the NC Administrative Offices of the Court, provides legal advocacy services to children who are alleged by local DSS to have been abused or neglected. Specifically, GAL volunteers are trained to advocate on behalf of the children they represent, ensuring that safety, permanency and well-being goals are addressed effectively throughout each legal proceeding.
- ***North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (NC DMH/DD/SAS)***⁴⁷, a division of the NC Department of Health and Human Services, is

⁴⁵ CCNC website reference

⁴⁶ Website

⁴⁷ Add website

charged with implementation of the state’s public mental health, developmental disabilities, and substance abuse programs.

- **Local Management Entities-Managed Care Organizations (LME-MCOs)**⁴⁸ are responsible for managing, coordinating, facilitating, and monitoring mental health, developmental disability, and substance abuse services across their catchment area. Specifically, the LME-MCOs authorize Intensive In Home Services and Day Treatment, as well as inpatient treatment placements, including: Therapeutic Foster Care, Group Homes, and Psychiatric Residential Treatment Facilities.
- **North Carolina Division of Public Health (NC DPH)**⁴⁹, a division of the NC Department of Health and Human Services, provides direct and indirect services to public and local health agencies, supporting their ability to perform core functions and implement statewide initiatives. Particular public health issues addressed by DPH include: chronic disease and injury prevention; environmental health; child and youth health; early intervention; immunizations; nutrition; and reproductive health.
 - **North Carolina Early Intervention Branch (NCEI)**⁵⁰, a branch of the NC Division of Public Health (Women’s & Children’s Health Section), is the lead agency for the state’s Infant-Toddler Program. The program provides supports and services for families and children under three years of age who have special needs through a network of sixteen Children’s Developmental Services Agencies (CDSAs)⁵¹. Specifically, CDSA personnel provide: service coordination; physical, occupational, developmental, and speech-language therapies; family support; special instruction; assistive technology; and other critical services.
 - **The NC Commission on Children with Special Health Care Needs**⁵² is an eight member panel, authorized by the NC General Assembly and administered through NC DPH. The

⁴⁸ Add website

⁴⁹ Add website

⁵⁰ Add website

⁵¹ Add website

⁵² Add website

Commission is charged with monitoring and evaluating the availability and provision of health services for children with special health care needs. Furthermore, the Commission recommends modifications or additions to the rules governing health service quality, delivery and access across this population.

- **North Carolina Department of Public Instruction⁵³** implements the state's public school laws, as well as the State Board of Education's policies governing pre-kindergarten through 12th grade public education.
 - **The Exceptional Children Division⁵⁴**, a division of NC DPI, is charged with ensuring that students with disabilities benefit from an appropriate, individualized education program in the least restrictive environment. *Note:* Children participating in the Infant-Toddler Program (0-3 years of age) transition to the school-based Early Intervention Program in their district by four years of age.
 - The **Council on Educational Services for Exceptional Children⁵⁵** was established through federal IDEA legislation, and codified through NC General Statute 115C-12. The Council is an advisory group to the State Board of Education, addressing children with special needs. Additionally, the Council assists in the development and implementation of policies related to service coordination for disabled students.

III. Competent Work Force

Successful implementation of *Fostering Well-Being* and the NC foster care HOCP requires that all foster children be cared for, and managed by, a competent work force that includes: medical personnel; resource parents; child welfare staff, clinical, and broader system of care staff and administrators; educators and education administration; community and

⁵³ Add website

⁵⁴ Add website

⁵⁵ Add website

state leaders; and advocates and other stakeholders. This work force must ensure optimal health and well-being of the population by:

- Providing a safe and stable home;
- Routinely screening the population for health and well-being concerns;
- Conducting standardized, comprehensive assessment;
- Referring foster children to appropriate resources, and ensuring access to care;
- Coordinating and facilitating service delivery and intervention;
- Providing case management services;
- Providing population oversight and coordination;
- Collecting health and well-being data;
- Participating in the proposed *Fostering Well-Being* program and the Well-Being Passport Program.

IV. Support Organizations and Programs

Successful implementation of *Fostering Well-Being* and the NC Foster Care HOCP requires the direct support of, and coordination with, public and private organizations and programs operating at the state and local level, including:

Advocacy

- ***North Carolina Foster and Adoptive Parent Association (NCFAPA)***⁵⁶ is a statewide resource parent advocacy agency, promoting quality foster care and adoptive services through: collaborative advocacy, education, provision of resources, reunification support, and networking.
- ***Strong Able Youth Speaking Out (SAYSO)***⁵⁷ is a statewide advocacy association supporting youth 14 to 24 who are, or have been, in the state's out-of-home care system. This platform allows youth to engage in advocacy and policy development activities, directly addressing issues that impact safety, permanency, health and well-being.

⁵⁶ Add website

⁵⁷ Add website

General Medical and Mental Health Supports

- ***North Carolina Child Treatment Program (NC CTP)***⁵⁸ is a statewide implementation platform supporting the dissemination of effective (evidence-based) child mental health treatment, with a particular emphasis on addressing emotional trauma. Foster youth, families, resource parents, and system of care professionals are able to access evidence-based clinicians in their communities through the NC CTP website.
- ***North Carolina Pediatric Society (NCPS)***⁵⁹ is the state chapter of the American Academy of Pediatrics and represents pediatric expertise on issues of policies and program including those related to foster care health and well-being.

Oral Health Supports

- ***CCNC CHIPRA Oral Health Task Force***⁶⁰ is a work group within CCNC that regularly convenes to develop and evaluate strategies to improve in dental care within the child Medicaid population.
- ***The NC Oral Health Collaborative***⁶¹, a program of the NC ***Foundation for Advanced Health***, was funded in 2013 to develop infrastructure and strategies to impact oral health policy, programs, and financing priorities, as well as enhance cooperation between primary care and oral health. The Collaborative will specifically address integration of oral health services in the medical home service delivery model. ..⁶²

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Supports for Youth Transitioning Out of Foster Care

⁵⁸ Available at www.ncchildtreatmentprogram.org

⁵⁹ Add website

⁶⁰ Add website

⁶¹ Website

⁶² DentaQuest Proposal

- **NC LINKS**⁶³ is a federal initiative funded through the John H. Chafee Foster Care Independence Program, and administered through NC DSS. The program provides critical services and resources to all youth foster youth between 13 to 21 years of age who are, or were, in foster care after the age of 13. The goal of the LINKS program is to assist youth in achieving successful transition into adulthood, specifically improving educational, vocational, medical and psychological outcomes. LINKS services and funds require youth to be active participants in the plan, although youth may opt-out of program at any time. Each DSS office has a designated LINKS coordinator.

- **Contractual Agreement for Continuing Residential Support (CARS Agreement)**⁶⁴ is an agreement signed by youth in the process of transitioning out of foster care, so that they might continue to benefit from financial and residential support between the ages of 18 to 21, and enrolled in full-time educational or vocational training.

- **Carolina Health and Transition (CHAT) Project**⁶⁵ is a state initiative to improve the quality and accessibility of health care transition services for youth, their families, and their medical providers across North Carolina, including foster youth transitioning out of care. Specifically, NC DPH, in collaboration with the Mountain Area Health Education Center, the Exceptional Children’s Assistance Center, and the Center for Independent Living, developed “The Health Care Provider’s Guide to Helping Youth Transition from Pediatric to Adult Healthcare,”⁶⁶ as well as companion guidebooks for youth and families. The Youth Guide includes information on establishing a medical home, insurance coverage, advocacy, and self-management of healthcare needs.

Educational Supports for Youth Transitioning Out of Foster Care

- **North Carolina Education and Training Voucher Program**⁶⁷ offers grants up to \$5,000 per year, for up to four years, to assist with college, university, and vocational training tuition and expenses. Youth who age

⁶³ Add website

⁶⁴ <http://info.dhhs.state.nc.us/olm/manuals/dss/csm-10/man/CSs1201c8-14.htm>

⁶⁵ Add website

⁶⁶ Add reference

⁶⁷ Add website

out of DSS custody, or youth adopted from foster care after 16, are eligible to apply.

- ***The NC Child Welfare Post-Secondary Support Program (NC Reach)***⁶⁸ was established by the NC General Assembly to assist with funding for a North Carolina community college, or one of the sixteen constituent institutions of The University of North Carolina system. To qualify, student applicants must have “aged out of” public foster care at 18, or were adopted from public foster care after 12 years of age.

- ***The NC Tuition Waiver***⁶⁹ is a program authorized by NC General Statute 115B-2, providing a tuition waiver for students attending a North Carolina community college, or one of the sixteen constituent institutions of The University of North Carolina. Applicants must be between 17 and 23 years of age, and aged out of foster care at 18 years of age.

⁶⁸ Add website

⁶⁹ Add website

2.5 NC Foster Care HOCP Implementation: Core Functions and Essential Activities

Fostering Connections to Success and Increasing Adoptions Act legislation requires each state to develop a foster care Health Oversight and Coordination Plan (**HOCP**) addressing: initial and follow-up health screenings; assessment, monitoring and treatment of identified health needs, including those related to emotional trauma; maintenance of an electronic health record for each child; development of a medical home network; oversight of prescription medications, including psychotropic medication; provision of expert medical consultation support; and development of transition plans that address health care access. The Child Welfare League of America has developed best practice standards to support federal mandates whereby each state must⁷⁰:

- Develop and monitor foster care health policies and procedures;
- Complete an initial health assessment within 24 hours of placement in foster care;
- Conduct a comprehensive health assessment shortly after entry into care;
- Generate an integrated health plan for each child in care;
- Maintain and monitor a current electronic health record across the foster care population;
- Develop and monitor service agreements with health providers and well-being experts, focusing on quality of care and targeted outcomes;
- Provide consultative support to caseworkers and other system of care professionals;
- Engage in problem-oriented review, as appropriate;
- Engage in routine review of each child's integrated well-being/child welfare plan;
- Periodically analyze clinical and administrative health care data for the purpose of utilization review, monitoring, and continuous quality improvement.

Fostering Well-Being Core Functions and Essential Activities

- ✓ *Assess individuals, population and system capacity*
- ✓ *Develop critical policies, procedures, program curricula and infrastructure*
- ✓ *Assure achievement of targeted outcomes at the level of the individual, population and community.*

⁷⁰ Child Welfare League of America. (2007). *Standards of excellence for health care services for children in out-of-home care; revised edition*. Washington, DC:

It is recommended that the proposed *Fostering Well-Being* platform develop and sustain core public health activities supporting the foster care population and the HOCP, including:

V. Assessment

It is recommended that state and designated ME leadership; *Fostering Well-Being* staff and Advisory Panel members; and medical home personnel support optimal foster child safety, permanency and well-being through ongoing *assessment activities* addressing:

- Individual-level and population-level health and well-being status, including: physical and reproductive health; oral health; development; behavioral-emotional functioning; cognition and educational-vocational functioning; social functioning; and transition readiness;
- Emerging health issues across the foster care population;
- Service capacity across geographic regions;
- Service utilization and cost, including cost-effectiveness data;
- Achievement of targeted health and well-being outcomes, at the level of the individual and population;
- Service satisfaction;
- Program implementation and dissemination benchmarks.

In order to support core assessment functions, state and designated ME leadership and staff; *Fostering Well-Being* staff and Advisory Panel members; and medical home personnel must:

- Identify targeted well-being goals, outcomes and clinical indicators;
- Develop a standardized clinical assessment battery, based on targeted outcomes and indicators;
- Develop a *Fostering Well-Being* Database and Well-Being Passport program, addressing content, format and data exchange protocols;
- Engage in geo-mapping activities, identifying service needs and service capacity;
- Develop a Continuous Quality Improvement (CQI) algorithm.

VI. Development

It is recommended that state and designated ME leadership and staff; *Fostering Well-Being* staff and the Advisory Panel members; and medical home personnel support optimal foster child safety, permanency and well-being through

development of:

- Legislation;
- Policies, procedures, and protocols;
- Programs;
- Technical assistance and consultation protocols;
- Workforce development and support strategies;
- Clinical tools and assessment batteries;
- Cross-system, integrated health and well-being service plan template;
- Critical infrastructure elements to support implementation of the North Carolina HOCP and the *Fostering Well-Being* initiative.

VII. Assurance

It is recommended that state and designated ME leadership and staff; *Fostering Well-Being* staff and Advisory Panel members; and medical home personnel support optimal foster child safety, permanency and well-being through ongoing *assurance activities*, focusing on:

- Development and support of a competent system of care workforce;
- Care coordination across well-being professionals and agencies;
- Oversight and coordination of prescription medication, including psychotropic medication;
- Oversight and coordination of emerging and/or costly health care issues, including: debilitating disease and disabilities; significant behavioral-emotional dysfunction; unintended pregnancy and parenting teens; obesity; substance abuse; cancer; HIV/AIDS; and life support and other end-of-life care issues;
- Increasing access to a high-quality, coordinated service array;
- Engagement of youth, families, and foster families in care planning, service delivery, and achievement of targeted outcomes;
- Successful transition of youth aging-out of foster care,
- Achievement of targeted safety, permanency, health and well-being outcomes.

To support core assessment function, state and CCNC leadership and staff; *Fostering Well-Being* staff and the Advisory Panel; and medical home personnel must:

- Develop a single, cross-systems service plan template;

- Develop a service referral algorithm, linking foster children to the most appropriate well-being service;
- Develop an algorithm for referral to intensive case management services for high-risk foster children;
- Provide intensive case management for all children who meet pre-determined criteria;
- Develop and implement a competency-based health well-being training platform for system of care professionals; families; and foster children and youth;
- Provide technical assistance and clinical consultation to service sites;
- Engage in individual and population oversight and coordination of service accessibility, appropriateness, outcomes, and effectiveness.

Section 2.6 Well-Being Health Service Array

Infants, children and adolescents in foster care are children with special health care needs,⁷¹ as they demonstrate disproportionately high rates of physical, oral, developmental, behavioral-emotional, cognitive and social difficulty, compared to the general population. In order to optimize health and well-being for all foster children, the state must assure access to an effective, comprehensive service array through a model home platform. The CWLA⁷² and the American Academy of Pediatrics (AAP)⁷³ have identified core components of an appropriate well-being health service array, including:

- Intake assessment and comprehensive assessment;
- Preventive and primary health care services;
- Specialized health care services;
- Oral health services;
- Early intervention and developmental services;
- Mental health services and substance abuse services;
- Coordination with educational services;
- Case management and coordination;
- Supports for parents, guardians, and resource parents.

It is recommended that Fostering Well-Being staff, the designated ME, and stakeholders develop and sustain a well-being service array that includes the following core components and strategies:

Components of the Fostering Well-Being Health Service Array

- ✓ *Assessment*
- ✓ *Preventive and Primary Health Care Services*
- ✓ *Specialized Health Services*
- ✓ *Oral Health Services*
- ✓ *Early Intervention and Developmental Services*
- ✓ *Mental Health Services*
- ✓ *Educational Service Coordination*
- ✓ *Case Management*
- ✓ *Caregiver Support*

I. Assessment

Each infant, child, and adolescent should be screened for health and well-being concerns upon entry into foster care, followed by comprehensive assessment within one month. Foster children should participate in ongoing monitoring and assessment every 30-90 days, thereafter, depending upon age⁷⁴. Comprehensive assessment requires the use of standardized protocols and assessment tools, specifically addressing:

⁷¹ Ringeisen H, Casanueva C, Urato M, Cross T. Special health care needs among children in the child welfare system. *Pediatrics* 2008; 122(1): e232 – 4.

⁷² Child Welfare League of America. (2007). *Standards of excellence for health care services for children in out-of-home care; revised edition*. Washington, DC: Author.

⁷³ AAP website reference

⁷⁴

- Health and well-being history;
- Physical health;
- Development;
- Behavioral-emotional health and functioning;
- Traumatic experiences, exposures, and symptoms;
- Cognition and academic/vocational functioning;
- Social well-being;
- General child and family service needs and supports;
- Permanency and safety needs and supports.

II. Preventive and Primary Care Health Services

The foster care population should have ongoing access to preventive and primary care health services through a network of medical homes. Services should be offered on an accelerated schedule due to their high-risk status, and include:

- Routine screening and assessment, using standardized protocols and assessment tools;
- General health monitoring and anticipatory guidance;
- Immunizations;
- Reproductive health services;
- Prescription medication management;
- Preventive dental services;
- Health education and promotion, focusing on the prevention of disease, disability and dysfunction, while promoting optimal health and functioning;
- Self-advocacy training and support.

III. Specialized Health Services

In addition to preventive and primary care health services, foster children often require access to specialized health services including:

- Emergency medical care;
- Medical and surgical subspecialty consultation, assessment, intervention and monitoring;
- Comprehensive reproductive health services;
- Nutrition services;
- Hearing and vision services.

IV. Oral Health Services

Each child and adolescent should be screened for dental issues within 30 days of entering foster care, following by routine monitoring and care⁷⁵. Basic dental screening and intervention may be offered through the medical home or a dental office; more complex oral health issues may require general dental and/or specialty care. Key components of the proposed oral health services array include: dental screen and treatment; the application of fluoride varnishes and sealants; and orthodontia and periodontal care.

V. Early Intervention and Developmental Services

Foster children between birth and five years of age should be screened for significant developmental issues upon entry into care, and participate in a comprehensive assessment within 30 days⁷⁶. Thereafter, they require access to early intervention and developmental services, offered in the least restrictive environment, and coordinated through their medical home, including:

- Screening and comprehensive assessment, using standardized protocols and assessment tools;
- Physical and occupational therapy;
- Hearing, speech and language therapy;
- Developmental therapy;
- And development of an Individual Family Service Plan (IFSP).

VI. Mental Health and Substance Abuse Services

Infants, children, and adolescents should be screened for significant mental health and substance abuse issues upon entry into foster care, and participate in comprehensive assessment within 30 days⁷⁷. Thereafter, they require access to a child and family-centered service array, addressing: behavioral-emotional status and functioning; traumatic exposure, experience and symptoms; and substance use and abuse. Services should be offered in least restrictive environment, and coordinated through the designated medical home, to include:

- Screening and comprehensive assessment using standardized protocols and assessment tools;
- Psychological, psychiatric and neuro-psychological evaluation and intervention;
- Evidence-based psychotherapy and other therapeutic services;
- Psychotropic medication management;
- Residential and psychiatric facility-based intervention;
- Substance abuse prevention, screening, assessment, and treatment services.

VII. Coordination with Educational Services

Foster children rely on educational stability and academic achievement for their short and long term well-being and success. The school setting not only provides necessary structure, predictability, and support, but also a critical gateway to specialized services. The medical home model is a platform for well-being information exchange, allowing for incorporation of academic and cognitive assessment and intervention data in the service plan, including:

- Enrollment, attendance, promotion/retention and graduation status;
- Academic and cognitive testing results;
- Special plans, accommodations, and interventions, including IEP and 504 plans;
- Ancillary supports.

VIII. Case Management and Coordination

The foster care population, children with special health care needs, require access to comprehensive services, coordinated through a medical home service delivery model. Specifically, individual-level oversight and coordination is provided by an assigned case manager embedded within the medical home and/or *Fostering Well-Being* program. Recommended case management activities^{78,79} include:

- Maintain individual health records, including Well-Being Passports;
- Integrate educational data into the Well-Being Passports;
- Ensure that health care consents are up-to-date for all services;

⁷⁸ AAP
⁷⁹ NCHQ

- Ensure that health care insurance enrollment is up-to-date;
- Communicate designated health information across youth, families, foster families, and system of care professionals;
- Ensure that health and well-being information is incorporated in permanency and transition plans;
- Engagement in continuous quality improvement activities, supporting the foster child and family; resource parents; the medical home and the *Fostering Well-Being* program.

IX. Services and Supports for Parents, Guardians, and Resource Parents

Biological parents, guardians, and resource parents require access to professional services and supports, enabling them to better meet the health and well-being needs of the children in their care. These services should be coordinated through the medical home and/or the local department of social services, and include:

- Training and support regarding key health and well-being issues effecting the foster care population;
- Referral for evaluation and/or intervention services, addressing caregiver needs;
- Referral for advocacy and social supports;
- Respite care.

Section 2.7 Workforce Development

Successful implementation of *Fostering Well-Being* and the state Health Oversight and Coordination Plan requires a competent workforce beginning with an understanding of the conceptual basis of this plan and followed by the practical application of activities outlined within it. Particularly critical to the success of this Plan are the child welfare staff, and resource parents who possess legal and/or physical custody and responsibility for children in foster care.⁸⁰

It is recommended that *Fostering Well-Being* staff, in partnership with Advisory Panel members and other experts, develop a training platform that supports optimal health and well-being across the foster care population, whereby:

- I. Training is:
 - *Competency-based*: A competency-based curriculum requires learners to demonstrate successful acquisition of targeted knowledge and skills;
 - *Web-based*: A web-based curriculum allows material to be updated routinely, and also allows learners to participate in training at any time, at their own pace, and from any location;
 - *Multi-tiered*: A multi-tiered training platform allows system of care professionals, families, and youth to benefit from complementary curricula, supporting the acquisition of targeted knowledge and skills.

- II. Curricula should address key issues and competencies, including:
 - Foster care-specific well-being goals and best practice standards;
 - Foster care-specific well-being issues, including: growth; physical, reproductive, oral, and mental health; development; medication administration, oversight and usage, including psychotropic medication; learning and education; and social functioning;
 - The impact of emotional trauma on child functioning;⁸¹
 - Principles of well-being screening and assessment;
 - An overview of health and well-being services and access;

⁸⁰ The recommendations contained in the recent Jordan Institute Report, "Recommendations for Building a Resource Parent Learning System for North Carolina, should serve as a helpful guide for developing curricula for child welfare staff and resource parents.

⁸¹ Project Broadcast, a state Division of Social Services initiative, is developing a Child Welfare Trauma Training Toolkit that likely will be expanded statewide.

- Health and well-being support programs and resources;
- Well-Being Passport and/or Well-Being Database access and use;
- A brief overview of *Fostering Well-Being* program and the North Carolina foster care HOCP principles.