Attachment B

2020-2024
Health Care Oversight and Coordination Plan

June 30, 2019

The Department of Children and Families (DCF) Office of Clinical Services (OCS) is charged with providing support, guidance and leadership across DCF on child and family health related matters and supports the overall safety and connectedness of children and families served by the department. OCS does this by developing and administering programs that provide seamless and quality prevention, intervention, primary and other healthcare services. The office also supports DCF's child welfare-serving Division of Child Protection & Permanency (CP&P) in ensuring families and children achieve appropriate physical and behavioral health outcomes. DCF is committed to comprehensively serving and meeting the medical and behavioral health care needs of children and their families. This work is also provided through DCF's Division of Children's System of Care (CSOC), New Jersey's public system designed to serve children, youth and young adults with behavioral health and substance use challenges, and intellectual and developmental disabilities. CSOC strives to ensure that all children and their families have access to a comprehensive system of care that provides timely and quality assessment, planning, services and supports that meet the needs of children/youth and their families. They also collaborate with many system partners statewide to leverage expertise of local communities. CSOC's practice model and system development approach for serving and supporting families employs wraparound values and the following core principles: Family Driven and Youth Guided, Interculturally Competent and Effective, and Community-Based. Services provided through CSOC are also clinically appropriate, individualized, provided in the least restrictive environments, protect the rights of children, families and caregivers, and collaborative across child serving systems.

Recognizing the joint efforts of the OCS and CSOC as well as CSOC's capacity to coordinate access to services within a community and systems development framework, OCS was integrated as a unit of the CSOC effective fiscal year 2019. This reorganization is intended to support the Department's strategic priorities that all children and families have the services and tools needed to meet their overall needs and remain safe, healthy and connected to their homes and communities. This also supports the Department's move toward services that are prevention-focused.

Additionally, work across the department is being transformed through the application of principles of being a trauma aware and informed, and healing-centered child welfare system. In recognizing and developing a more comprehensive understanding of the impacts that child abuse and/or neglect varies amongst individual children many child welfare agencies are creating systems that are more responsive and sympathetic to trauma. The National Child Traumatic Stress Network (NCTSN, n.d.) defines a trauma informed and family service system as, "one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system,

including children, caregivers, and service providers."[1] With this understanding, and acknowledging trauma does not look the same in every child, DCF has begun to shift its practice to integrate a more trauma informed approach into areas such as: policy, workforce development, child screenings and assessments. As part of the evolution of becoming a trauma-informed agency, DCF understands the need to look beyond the visible impacts of a child being a victim of child abuse and/or neglect. In turn, addressing the behavioral/mental health needs of children entering placement is an important component of CP&P's case practice model and core values.

Trauma is a critical factor for children who have experienced maltreatment. Many children with child welfare involvement often show signs or indicators that their overall well-being and development has been impacted by traumatic experiences such as developmental delays and behavioral issues. Placement involvement and other adverse events experienced by children can impact many areas of their lives, including their overall medical and behavioral health and development. Adverse Childhood Experiences (ACES) are traumatic events that occur in a child's life before the age of 18 and can include factors such as abuse and neglect, and parental substance abuse, domestic violence, and divorce. These events can have potential negative effects and are directly related to the overall health and well-being of children throughout their lives. Research suggest that adults who experience multiple negative childhood experiences have an increased risk for poor health outcomes such as substance abuse and depression.[2] DCF recognizes the importance of creating policies that assist the entire department with helping children and their families prevent, respond and navigate through poor and traumatic childhood experiences. The Coordinated Health Care Plan laid the foundation for health care case management in New Jersey's child welfare system and provided DCF with opportunities to develop a more comprehensive understanding of how adverse and traumatic experiences impact children and their overall physical and social-emotional growth and development.

DCF understands and continues to demonstrate its ongoing commitment to transparency and accountability by producing reports, facilitating discussions with internal and external stakeholders, and focusing on sustaining the necessary infrastructure to ensure that we will be able to continue to improve services and outcomes. The commitment to accountability around our data and practices, allows us to gain trust from our families, community partners and stakeholders. It also provides opportunities for the public to expand its knowledge about our work and commitment to every individual we serve. In

[1] Child Welfare Information Gateway. (2015). *Developing a trauma-informed child welfare system.* Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/trauma_informed.pdf. Accessed November 5, 2018.
[2] Felitti, V.G., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., & Koss, M.P. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine* 14(4), 245-258.

addition, reviewing and analyzing our data provides opportunities for CP&P to make informed decisions while identifying areas of strength and areas that need improvement. This data allows us to gain additional knowledge, evaluate, implement, provide internal and external feedback, and identify possible solutions. OCS had primary responsibility for creating and implementing New Jersey's 2015-2019 Health Care Oversight and Coordination Plan and as part of New Jersey's CSOC can now use a prevention-focused approach in establishing and integrating the 2020-2024 plan into best practice for all children served by DCF.

New Jersey Health Care Oversight and Coordination Plan for 2020 – 2024

DCF sought to develop a health care management system that is grounded in comprehensive coordination, planning, and case management. To achieve these goals DCF partnered with Rutgers University to DCF build a well-coordinated system comprised of two primary goals to address the overall health care needs of children in out-of-home placement. The first goal was to identify and address the health care needs of children by conducting immediate screening and assessments. The purpose of these screenings and assessments were to identify any needed services prior to children entering placement and mitigate any further trauma. The second goal was to establish a plan for ongoing health care case management. The purpose of ongoing health care case management is to ensure each child's needs, along with the standards for preventive health care, are continuously met.

Through the original Coordinated Health Care Plan for children in out-of-home placement created in 2007, shortly after the creation of DCF as a cabinet-level department, DCF was able to reform the health care system for children in placement by assessing where there were service gaps, areas of strength, and areas in need of improvement. The assessment was done using data collection and analysis, system mapping and best practice review and revealed that while there were pockets of excellence and promising practices in NJ, fragmentation of health care services and lack of coordination were the largest challenges.

This work led to the development of a structured model to ensure primary and preventive health care needs of children entering out-of-home placement are met. The development of Coordinated Health Care Plan and teaming with Rutgers University, has provided DCF the ability to implement the plan and build the capacity to provide comprehensive and continuous coordination of quality health care case management to support the needs of children in placement within the 46 CP&P Local Offices. As part of this capacity building, DCF and Rutgers University/CHP staff have focused on continuity of care for children from the time they enter placement until they exit care, engagement of biological family in health care planning and follow-up, as well as the appropriateness and timeliness of mental/behavioral health care services.

As noted earlier, an advancement since the previous health care plan is the reorganization and integration of OCS and CSOC. This level of partnership and

coordination of health care case management allows DCF to ensure children in placement receive appropriate medical and behavioral health care supports and services.

Overview: Child Health Care Case Management in New Jersey

The child health care case management model was designed to ensure children in placement have all their medical and behavioral health care needs met. DCF collaborated with our Federal Monitor, DCF contracted child welfare nursing staff, and the New Jersey Office of the Child Advocate, to establish standard measures to track medical and behavioral health care outcomes for children in out-of-home placement. These child health measures were developed to support DCF in building a cohesive system that could meet and achieve the identified child health performance goals. The move towards standardized measurement was critical to DCF's efforts to ensure the medical and behavioral health care needs of children in out-of-home placement are addressed. DCF's performance data were designed to measure, identify and address the needs of a child at the onset of entering out-of-home placement and throughout their placement episode and to monitor each child's progress, needs and developmental milestones. Child health measures are also significant, as they represent a combination of ensuring timely identification and attention to health care issues of children in placement. In turn, these measures help to ensure consistent and ongoing quality health care, which supports several priorities of DCF's Strategic Plan.[3]

DCF created Child Health Units (CHUs) to ensure the child's medical and behavioral health care measures would be achieved over time for children in placement. Consequently, the CHUs were developed with the vision of embedding the nursing staff into the culture of the CP&P Local Offices to collaborate with case workers, other Local Office staff, and kin and unrelated resource families. Another objective was to provide Local Offices with staff members who possessed the expertise and knowledge needed to navigate through the various facets of the health care system. The addition of the CHUs provided CP&P the ability to ensure seamless coordination of services as well as proper review and follow up of medical records and assessments. Nursing staff ultimately became responsible for completing and tracking the progress for all health-related duties previously performed by CP&P caseworkers. This philosophy is supported by the American Academy of Pediatrics (AAP) who stated, "Health care management is the responsibility of the child welfare agency, but it is a function that requires medical expertise."[4]

[3] http://www.nj.gov/dcf/about/NJ%20DCF_Strategic%20Plan_2016_2018%201116%20FINAL.pdf

[4] American Academy of Pediatrics (AAP). *Fostering Health: Health Care for Children and Adolescent in Placement.* 2nd Ed. 2005.

The nursing staff responsibilities include, but are not limited to the following:

Child Health Unit Responsibilities
• **Perform Pre-Placement Assessments (PPA)** • **Obtain and review medical records** • **Ensure comprehensive medical exams are conducted and immunizations are up to date** • **Complete mental health screenings** • **Monitor psychotropic medications and treatment** • **Assign an acuity level to every child who enters placement** • **Manage individual health care case management records** • **Work collaboratively with MCO Care Managers** • **Perform routine in-person contact (with child and caregiver), developmental monitoring and follow up** • **Work closely with resource families on a continuous basis to follow up on all recommendations and ensure they are resolved** • **Team with staff and community partners to support transparency, seamless services and system capacity to identify emerging trends related to child health outcomes** • **Prepare Provide Child Health Passports to resource parents**

The CHUs were a cornerstone of DCF's early reform efforts and they have built upon this foundation to expand their efforts on enhancing trauma-informed practice in New Jersey. The CHP has also proactively ensured that New Jersey's child health care case management model remains a national model for children in out of home placement. Work done by OCS, Rutgers University and the nursing staff at the Local Office level provides comprehensive oversight of children in placement to ensure the child health outcome foundational elements continue to be maintained. The measures highlighted below and presented throughout the remainder of this plan reflect well child and preventive care best practices.

Child Medical Health Measures	Child Behavioral/Mental Health Measures
• Pre-Placement and Entry Medical Assessments • Appropriate Medical Assessment and Treatment-Comprehensive Medical Examinations (CME) • Follow-Up Care and Treatment • Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • Immunizations • Dental Examinations	• Mental Health Screening • Mental Health Assessment • Follow-Up Care and Treatment

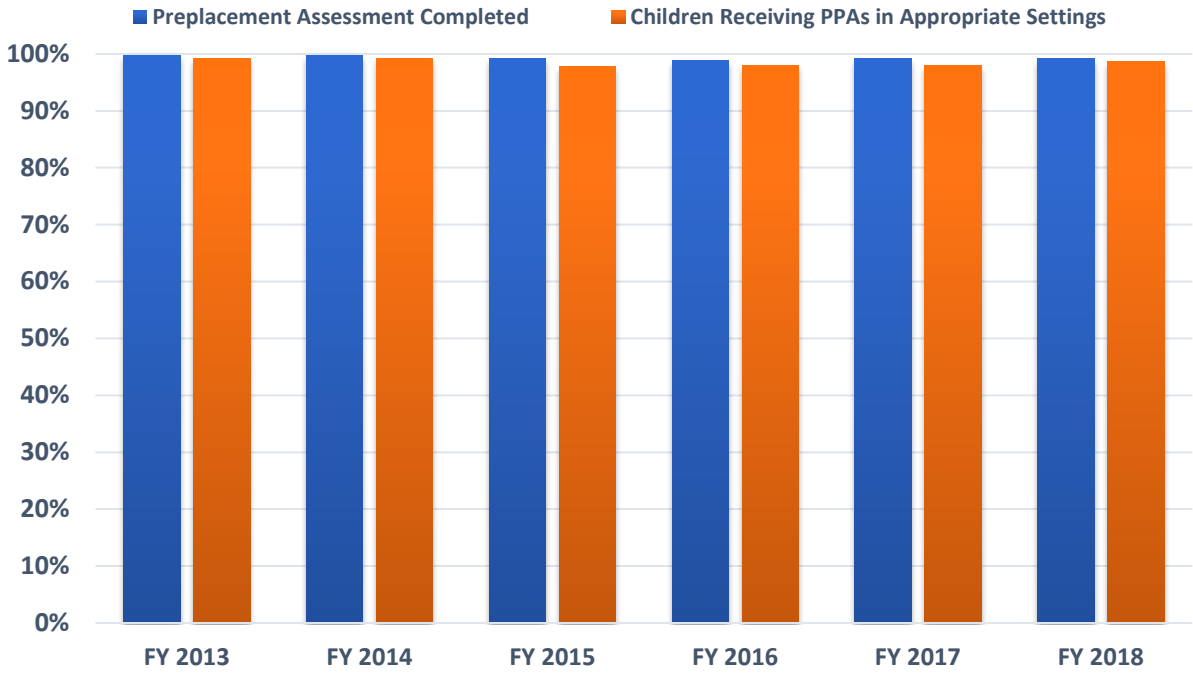
Schedule for Initial & Follow-Up Health Screenings

Pre-Placement Assessments

Safety and stability are two of the primary concerns when it is determined that a child is no longer safe and stable in his or her own home. A significant part of ensuring a child is safe and stable is providing thorough health care case management, including timely screening and assessment. As part of New Jersey's Coordinated Child Health Care Plan, all children are required to receive a pre-placement assessment (PPA) within 24 hours of removal from their home.[5] The purpose of this assessment is to assess health status of the child at the time of removal, identify, document and develop a plan to address the child's immediate (urgent and non-urgent) health care needs, document injury if present, and ensure each child is free from contagion or identify conditions that might inform decision-making about the most appropriate care setting for the child.[6] PPAs are conducted by professionals and in environments that minimize additional trauma surrounding placements, using the following choices: (1) the child's own health care professional; (2) CHU nurse in a CP&P Local Office; (3) specially designated health care professional, such as pediatricians or Federally Qualified Health Centers within the local CP&P community; and (4) in very limited circumstances a hospital emergency room.

[5] The only exception is when a child enters placement from a medical setting. See DCF Policy Manual CP&P-V-A-1-1300

[6] Ibid



DCF has long recognized that emergency room exams create additional trauma for children entering placement and has adopted policies and practices to ensure children receive PPAs in non-ER settings and only in emergency rooms when appropriate. Appropriate reasons for PPA to be conducted in an emergency room could include, e.g., the child needs emergent medical attention or the child is already in the emergency room when CP&P receives the initial referral.

Source: NJ DCF Administrative Data (extracted April, 2019)

PPAs allow CP&P to obtain information for children entering placement regarding their current physical and behavioral health status. These assessments assist the CHU nurses, CP&P caseworkers and resource caregivers with ensuring the child's immediate physical and behavioral health care needs are identified, understood and addressed to help minimize the trauma of entering placement.

Comprehensive Medical Examinations

DCF's responsibility and commitment to ensuring children who enter a CP&P placement receive a full medical and behavioral health assessment is embedded into our health care case plan and management. This level of screening allows CHU nurses, front line staff, and professionals (e.g. physicians, social workers, and therapist) to identify and screen current and past medical and behavioral health concerns, including ACES. In order to gain the best possible insight into a child and their family's history, it is important to conduct comprehensive screenings and assessments. DCF and CHP are committed to identifying any physical and/or behavioral health needs of children entering placement is essential to provide seamless care and ensure their overall needs are addressed. To this

end, the comprehensive medical examination (CME) process was developed to improve and ensure all children entering placement receive services and access care to address any identified needs.

Within 30 days of entering out-of-home care for the first time, every child must have a CME. A CME is a full medical assessment that provides an overview of the child's current status, physical and developmental history, medical record review based on what is available, an initial mental health screening and physician recommendations. CMEs are provided by the state's Regional Diagnostic and Treatment Centers (RDTCs), a contracted community-based provider or the child's primary care physician. CHU nurses are responsible for scheduling CME appointments and ensuring all necessary parties (i.e., caseworker, resource parent, etc.) are available, and for gathering all required documents and preparing all applicable physical and behavioral health information for individual physicians and therapist when applicable. Through a partnership with the Division of Medical Assistance and Health Services (DMAHS), the state Medicaid agency, contracted providers are entitled to receive an enhanced rate from Medicaid for performing the CME and are required to complete two forms to document the service: An Initial Report at the time of the visit, and the Final Report within 14 days.

Since FY2013 CP&P has maintained steady performance with the majority (83% average) of children receiving a CME within 30 days of entering out-of-home care, and an overall 97 percent of CMEs being completed within 60 days. In 2016 and 2017, there were slight increases in children receiving CMEs within 30 days and subsequent decreases in the numbers completed 60 days of entering placement. This trend did not continue into 2018 and, as a result, the OCS and CHUs have refined the use of the data to identify whether the recent increase in time to CME completion is an outlier or if there are new barriers to obtaining this service.

Mental Health Screenings

Because trauma exposure rates are nearly 90 percent amongst children in placement[7], initial and ongoing screening and assessment are instrumental in identifying and assessing the overall needs of children with child welfare involvement who enter placement. Routine and regular screening allow child welfare agencies to evaluate a child's needs on a continuous basis and to ensure they receive safe and appropriate supports and services. The screening of children who enter placement is also supported on a broader level, as child welfare agencies throughout the United States are incorporating screenings to assess trauma and other behavioral health care needs. DCF uses screenings to inform practice, identity appropriate services and placements, and to equip caregivers with background information that assists them with understanding and

[7] U.S. Department of Health and Human Services. (2013, July 11). [Letter to State Medicaid Directors]. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf. Retrieved November 16, 2018.

caring for the individual traumas and needs for each child. Using data from screenings and assessments is supported by research which suggest that this approach allows child welfare systems to assess the efficacy of supports and services for individual children and the overall population being served.[8] CP&P recognizes the trauma children may experience when removed from their homes and understands background information can be limited. As a method of best practice, each child entering a CP&P out-of-home placement receives a mental health screening to determine if a mental health assessment is needed. Behavioral (mental) health screenings assist with determining if a child has an identified or suspected mental health need and to learn about their history of trauma.

Each child who enters out-of-home placement in New Jersey receives an initial mental health screening by a qualified professional, which aligns with having a trauma informed approach.

Children entering placement are screened utilizing at least one of the three following options:

Mental Health Screening Options
1. **Screening by a CHU Nurse utilizing the Bright Futures Pediatric Symptoms Checklist**[9] 2. **Screening by the physician/health care practitioner conducting the CME utilizing their identified developmental screening tool or** 3. **Screening by a CP&P caseworker using a tool developed by DCF, which has been adapted from the Mental Health Screening Tool developed in California.**[10]

In 2016, CP&P began to partner, through CSOC, with the state's providers of Mobile Response and Stabilization Services (MRSS) to provide services to children and resource caregivers at the immediate time of placement. MRSS is CSOC's urgent response component. The MRSS providers offer 24/7 response to children/youth experiencing crisis as defined by their families with a goal of stabilization by providing supports and services within system of care framework. MRSS is provided to children and licensed resource and kinship caregivers at the immediate time of placement given the traumatic circumstances are understood to occur at the time of placement. This process requires CP&P staff members to contact CSOC's Contracted System Administrator (CSA), which is CSOC's single point of entry and access to care, to refer all children/youth ages three

[8] ibid
[9] https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
[10] http://www.cebc4cw.org/assessment-tool/the-mental-health-screening-tool/

through 18 that are being placed in resource or kinship care. The purpose of this is to connect children/youth and caregivers to their local MRSS provider, if the Care Management Organization (CMO) is not already involved with the child at the time of placement. The main goal of MRSS is to address stabilization and mitigation of trauma for children/youth at time of placement by offering support and education to children/youth and licensed resource and kinship caregivers. Stabilization is an important factor in avoiding the re-traumatization that can occur from further changes to placement.

Mobile response is delivered to children/youth experiencing escalating emotional symptoms, behaviors or traumatic circumstances which have compromised or impacted their ability to function at their baseline within their family, living situation, school and/or community environments. These crises arise from situations, events, and/or circumstances that are unable to be resolved with the usual resources and coping abilities and jeopardize the development of adaptive social and emotional skills. These children/youth, without intervention, could likely require a higher intensity of intervention to address their needs and/or prevent further decline in life functioning. Without MRSS, children/youth may be at risk of psychiatric hospitalization, out-of-home treatment, legal charges, or, loss of their living arrangement, including out-of-home placement through CP&P. In particular, children/youth who have experienced implicit or explicit trauma may be at increased risk for an acute decline in their baseline functioning or for being in jeopardy of a change in their current living environment.

Monitoring Follow-Up Care

DCF conducts a case record review process every six months for reporting follow-up specific to specialty care needs of children entering placement. The Health Care Case Record Review also reports on indicators not typically captured from DCF's other data sources and involves reviewing a random sample of CHU health care records. Through these ongoing health care case record reviews, DCF analyzes recommended follow-up care and treatment identified in CMEs, mental health screenings, assessments and timely delivery of this information to resource parents. DCF also began to closely discuss and analyze best practices around effectively addressing follow-up care and identifying any potential gaps in provision of follow-up care services that could be rectified. DCF is now able to distinguish those cases where only some of the follow-up care needs can be addressed and determine if barriers are due to community or internal challenges. One of the primary functions of DCF's Health Care Case Management model is to continually assess coordination of services and each child's ability to access and receive quality medical and behavioral health care and follow-up care services. The monitoring work conducted through the Child Health Program for DCF is represented throughout the remainder of this plan.

Mental Health Assessment

Mental health assessments provide a comprehensive and detailed evaluation of a child's current mental health state. Consequently, assessments help determines what follow-up care and treatment a child may need. Children already receiving mental or behavioral health or psychiatric services at the time of placement are assumed to be receiving regular screening, re-evaluation, and treatment as part of their services. However, additional concerns may present themselves that may warrant a referral for mental health assessment following placement to assist with ensuring appropriate services and supports are being provided to each child.

Follow-up related to Medical Health Care

The CME identifies if children entering placement need immediate follow-up care or treatment related to their health care needs. The CME also provides necessary recommendations for CHU nurses and CP&P staff members to ensure children in placement receive ongoing follow-up care with appropriate primary and specialty services. Follow-up care and services are essential components of helping to ensure the identified medical needs of children in placement are addressed and met on a continuous basis.

Updating and Appropriately Sharing Medical Information.

DCF's SACWIS system NJ SPIRIT includes specific areas where information related to a child's medical and mental health should be recorded. These electronic windows within NJ SPIRIT are primarily used and updated by the CHU, but CP&P caseworkers can also record significant health-related information as it becomes known. All information recorded within the medical/mental health windows of NJ SPIRIT become part of the child welfare case record. There is also the ability to upload pertinent medical documents directly into NJ SPIRIT. Similar to caseworkers, CHU nurses are mandated to have face-to-face contact with all children in placement and their caregivers. The schedule for these contacts is based on the child's acuity level, which is guided by their current and up-to-date health needs. At a minimum, CHU nurses have initial contact with the child and caregiver within 2 weeks of placement, followed by quarterly ongoing visits. CHU nurses are also available to substitute caregivers, treating medical providers and the caregiver(s) the child has been removed from to answer questions about the child's health needs and/or follow-up care plan.

Since April 2011, CP&P adopted use of the Health Passport and Placement Assessment form (Health Passport). The forms are available, accessed and updated through NJ SPIRIT. CHU nurses complete Health Passports within 72 hours of beginning health care case management and a copy is provided to the CP&P caseworker and child's caregiver

within 5 days of placement. It includes general age-appropriate and child-specific anticipatory guidance that can be utilized by the Division in making a safe placement decision and to alert the child's health care practitioner to the child's health needs. The Health Passport is created after every face-to-face contact between the CHU nurse and provides for the child a current summary of nursing assessment, acuity level, caregiver requirements, and short-term follow-up health plan. CHU nurses update any medical or behavioral health changes to the child's Health Passport in NJ SPIRIT as needed, and distributes updated versions to the child's caregiver(s). The up-to-date Health Passport is also provided to an adolescent who is exiting care at or beyond age 18. The following information is also reflected and maintained in the Health Passport if known: significant birth history, history of hospitalizations, injuries and/or illnesses, significant childhood diseases, developmental history, education classification, counseling services, family medical history, all medical providers, and types and results of medical/laboratory testing.

Ensuring Continuity of Health Care Services

Establishing a medical home for every child in placement is an on-going consideration within DCF and OCS. Efforts are made to provide for continuity of care to the extent possible. When feasible, each child's care continues to be provided by the Primary Care Physician (PCP) in place prior to placement. When that cannot occur the substitute caregiver is encouraged to connect the child to a PCP as soon as possible following placement. To the extent possible the child is maintained in the same HMO so coverage for and access to needed services remains. Identified services are continued as needed, through the same provider whenever possible. Communication between and among CHU, CP&P caseworker, HMO care manager, placement family, family of origin is encouraged and facilitated through the CP&P Case Practice Model.

Psychotropic Medication Policy & Practice and Mental Health Initiatives

Oversight of Prescription Medicines, Including Protocols for the Appropriate Use and Monitoring of Psychotropic Medications

Published in 2017[11], DCF developed a comprehensive policy concerning the prescribing, use and monitoring of psychotropic medication for DCF-involved children who are in out of home placement and any child under CP&P custody. DCF's goal has been to ensure the policy helps position the Department and its partners to promote good practice in the interest of better serving children and families. Key components of the policy include criteria for Informed Consent and Treatment Plans and appendices about Psychotropic Medication Parameters to be used when considering consent for treatment; Psychotropic Medication Safety Monitoring Guidelines; and additional resources for CHU and CP&P staff. The OCS participated in the Center for Health Care Strategies, Inc. *Psychotropic*

[11] https://www.state.nj.us/dcf/policy_manuals/CPP-V-A-1-1500_issuance.shtml

Medication Quality Improvement Collaborative (PMQIC) project through FY2016. At its completion, New Jersey's goals of monitoring psychotropic medication utilization and improving compliance with components of the New Jersey Psychotropic Medication Policy continued to provide information about trends, identify areas for further study, and demonstrate compliance. This targeted review has been strengthened by the institution of a process for follow-up of individual children and youth identified in the review in collaboration with the nursing team. Increased capacity in NJ SPIRIT to capture additional information regarding psychotropic medications has been added, and the work toward a strategy to crosswalk data between CHU and CSOC continues.

CHU nurses maintain information in NJ SPIRIT for medications prescribed to children in placement, including Psychotropic Medication. This information for psychotropic medications includes the diagnosis for which each medication is prescribed, the presence of a signed consent for each medication and verification of a treatment plan with non-pharmacological interventions is also documented in NJ SPIRIT. This information is then downloaded quarterly into a report, a "tracker", for the OCS and reviewed by the CHU. Children are "tracked" by age and number of prescribed psychotropic medications. Trackers are submitted for additional review by the Child and Adolescent Psychiatrist, and the Child Health Program APN for Child Behavioral Health. All children who present with additional risks, such as children under age 6 and those on more than four medications, are reviewed individually.

OCS has identified a need to enhance capacity for monitoring adherence to the DCF Psychotropic Medication Policy and has plans to contract with an APN consultant to work collaboratively with the child and adolescent psychiatrists. The addition of a full time APN will provide increased monitoring and oversight capacity to ensure ongoing adherence with DCF's psychotropic medication policy, with an emphasis on analysis of system-wide and sub-population data to support both quality assurance and quality improvement activities, and to provide CP&P leadership with meaningful data on local and statewide trends. This additional capacity will also support increased focus on adherence to non-pharmacological medication treatment requirements and inform service development and realignment.

Training for workers to build their knowledge base on psychotropic medications and enhance their capacity to empower parents to ask appropriate questions regarding this topic, was developed by University Behavioral HealthCare (UBHC). This curriculum is implemented in the training of CP&P, CSOC and CMO staff.

Engagement of Community Medical and Non-Medical Professionals

Pediatricians

DCF contracts the services of pediatricians who, working through one of the RDTCs (see below), and are available to assist CP&P staff. They conduct medical chart reviews; strategizing with CP&P casework & CHU staff on addressing care for children with particularly complex health issues; providing guidance around consenting for non-routine medical procedures; and serving as liaison between health care providers and CP&P Local Offices to address emergent issues and concerns. Additionally, they provide 24/7 phone access to CP&P field staff and the screening center.

DCF Child/Adolescent Psychiatrists

DCF contracts with one full-time and one part-time Child/Adolescent Psychiatrist who provide guidance and training on the identification, evaluation, diagnosis and treatment of children and youth with mental health needs; and conduct medical chart reviews. They also engage in dialogue with providers regarding specific children and their appropriate treatment plan and provide guidance and support to CP&P Local Office staff through case consultation on a daily basis. As part of their role, they provide leadership around quality assurance efforts in the area of psychotropic medication utilization and ongoing efforts to strengthen DCF's psychotropic medication policy and practice; and assist in the development of the CP&P Mental Health Screening Program.

DCF Pediatric Neuropsychologist

DCF contracts with a full-time Pediatric Neuropsychologist Consultant. The work of the Pediatric Neuropsychologist includes providing leadership around learning, behavior, and the association with the development of brain structures and systems through brief trainings within the CP&P Local Offices; engaging in dialogue with educators and others regarding the treatment for specific children; and supporting CP&P caseworkers with consultations on cases where clarification is needed about a child's behavioral or educational needs. The Pediatric Neuropsychologist is a member of the Interdisciplinary Team (I-Team), an intradepartmental group whose mission is to develop policies and provide input to care for children with significant developmental disabilities.

Regional Diagnostic and Treatment Centers (RDTCs)

RDTCs in New Jersey are legislatively mandated to provide diagnostic and treatment services to children believed to be victims of physical abuse and neglect or sexual abuse. DCPP refers children it believes have suffered abuse or neglect to the RDTC for evaluation and treatment and DCPP utilizes RDTC reports as one component of its investigations into allegations of abuse and neglect. RDTCs receive funding from DCF for Child Abuse and Child Sexual Abuse examinations, serve as legislatively mandated

Centers of Excellence in this area, prepare reports and testify at court proceedings as necessary. These centers are also contracted to conduct Comprehensive Medical Exams (CME) and Comprehensive Mental Health Assessments.

Multi-Disciplinary Treatment Teams

CP&P staff, in addition to medical personnel from the State's RDTC and law enforcement, participate in Multi-Disciplinary (MDT) teams charged with reviewing individual children's cases and determining how to meet the child victim's needs. CSOC also collaborates with system partners at the local and state level to interpret results and identify areas of growth to best support decision-making and planning. CSOC convenes I-Team conferences to address the behavioral health and/or co-occurring needs of children and youth involved with DCF, as well as partners with the New Jersey Department of Human Services and County Inter-Agency Coordinating Councils (CIACC), which are local county-based planning and advisory groups. Partnerships like these assist DCF with identifying trends, strengths, and areas in need of improvement as well as sustaining accountability.

Forensic Evaluation Services by Psychologists

DCF's *Guidelines for Evaluations in Child Abuse/Neglect Proceedings*, the Department's first comprehensive effort to address the use of expert evaluations in child welfare and child protective services proceedings, were adopted as policy in November 2012. The guidelines lay out best practices for forensic evaluations and assessments that may be needed during child welfare/child abuse/neglect investigations or to assist with permanency planning and are intended to improve the quality of expert forensic evaluations provided for DCP&P and the courts, as well as the ability of stakeholders involved in child welfare proceedings and child protective service matters to make better use of them. The OCS worked with the Office of Training and Professional Development (OTPD) to design and implement a day-long course for DCP&P case workers and supervisors to support implementation of DCF's Guidelines for Evaluations in Child Abuse/Neglect Proceedings. The training is intended to strengthen the understanding among CP&P staff about the role of forensic evaluations; when to use them; how to formulate good and appropriate evaluation questions; what information to provide to evaluators; and what to expect in terms of a deliverable.

Following the release of the Guidelines, DCF issued its first Request for Qualifications for Forensic Evaluation Services by Psychologists (RFQ) in December 2012 as a means of expanding the existing pool of psychologists who perform forensic (mental health) examinations. The RFQ was designed to not only increase the number of resources available to CP&P but also to improve upon the quality of psychologists by establishing some minimum standards those psychologists must meet. The RFQ is updated and reissued annually.

Rutgers University was contracted to create DCF's *Coordination Center for Child Abuse and Neglect Forensic Evaluation and Treatment* (NJCC) in July 2015 to assist the Department, the network of RDTCs, and other providers conducting forensic evaluations and providing treatment recommendations for the Department by:

- Ensuring that CP&P, and children and families have access to Centers of Excellence in the area of child abuse and neglect assessment and treatment within New Jersey
- Supporting and disseminating best practices to improve the quality of child abuse and neglect assessment/evaluation and treatment
- Training, coaching, and providing technical assistance to the forensic evaluation provider community
- Advancing understanding and scholarship in the area of child abuse assessment
- Assisting DCF with ongoing planning activities in the area of child abuse neglect evaluation and treatment

The NJCC has completed quality reviews of psychological evaluations and dissemination meetings for two of the RDTCs catchment areas, the Dorothy B. Hersh RDTC catchment area (covering eight counties) and the Metro RDTC catchment area (covering one county). The NJCC is in the process of completing the quality reviews for the CARES catchment area (covering seven counties) and anticipates the reviews will be completed by the end of June 2018. The dissemination meetings serve to review the findings of the qualitative reviews, discuss areas of strengths and needs, and to allow CP&P and the psychologists to reflect on their own practices and how they can improve service delivery.

The input from CP&P and the psychologists at the dissemination meetings, in addition to the findings of the study, has informed the development of trainings and deliverables. The NJCC is writing six brief reports that focus on the use of psychological assessment tools/measurements and cultural competency that will be made available to psychologists and DCF leadership, likely using a website and portal system. The NJCC is also developing various virtual trainings/webinars regarding the operationalization of the Forensic Guidelines, best practices for psychological evaluations, how to demonstrate cultural competency, and the intersect of mental health evaluations and client substance use.

The OCS hopes to create a universal psychological referral form to be used with contracted providers to provide formality around the referral, encourage critical thinking about the reason for referral and referral questions, and to prompt CP&P to share appropriate collateral information. The universal referral will complement a *Mental Health*

Evaluation Desk Guide which will be available in FY2020 to assist CP&P in identifying what type of mental health evaluation might be most appropriate for a client.

Procedures and Protocols to Ensure Children in Placement are not Inappropriately Diagnosed

In New Jersey, we are exploring building a systematic, well-resourced approach for screening children under the age of five. To support this effort, DCF is currently teaming with New Jersey's Department of Human Services' Division of Medical Assistance and Health Services (DMAHS). One aspect of this partnership is the *Aligning Early Childhood and Medicaid* initiative which is engaging with Medicaid and other key stakeholders around coordinating care for children ages zero to three. In addition, utilizing new resources to allow for autism services to be covered as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This work is an opportunity to develop a risk-stratified model of screening, care coordination, treatment and service delivery for Medicaid recipients which also will allow for alternate payment methods for families involved with DCF.

The integration of OCS into CSOC also supports these efforts and helps to ensure that children in placement remain connected to resources and are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions or developmental conditions, and are placed in settings appropriate to their true needs. This reorganization will assist DCF in becoming a trauma-informed and healing-centered system that is moving towards prevention-focused practices. As part of DCF's strategic plan, CSOC is undergoing a reorganization that includes the establishment of a stakeholder advisory group that will inform and update future efforts towards promoting integrated health in primary and behavioral healthcare systems. The focus of CSOC's goals will be around promoting integrated health and behavioral health, building capacity to deliver evidence-based and best practice interventions and services, and enhance CSOC's capacity to ensure equitable access.

Ensuring Health Care Needs of Youth Aging out of Placement

Since September 2010, it has been DCF practice that youth aging out of placement receive additional instruction related to their health care needs. This practice requires that youth, as they approach their 18th birthday, are provided with instruction regarding the importance of selecting a health care proxy and are provided with the option to execute such a document, as well as information regarding health insurance and health related resources. The instruction takes place in coordination with development of youth-directed Transition Plans. This instruction augments other State efforts to build life skills competencies with youth as they age into adulthood. Tools developed to assist casework and CHU staff include: a tri-fold pamphlet, medical proxy form, revised Transitional Plan

for Adolescents, descriptive policy, and an updated health services section of DCF's Adolescent Services Guide. Ongoing tracking of the practice is done through supervisory review of the transitional and case plans.

CHU nurses also independently engage with youth ages 18-20 with open CP&P cases who are receiving services, whether or not they are in placement. Nurse engagement includes an assessment of the youth's ability to engage and navigate the health care system. CHU nurses provide the youth and young adults with ongoing health education and guidance to improve their ability to independently navigate the healthcare system are no longer involved with CP&P.

The OCS has administered Medicaid Extension for youth ages 18-21 since 2001, based on the Chafee Act. With the advent of the new Federal Health Care Law effective January 1, 2014, this program was collaboratively adjusted to provide for Medicaid for eligible former foster youth through age 26. This reformed program is now known as *Medicaid Extension for Young Adults*, or MEYA. OCS built on the partnership with DMAHS to increase inter-departmental capacity to enroll eligible former foster youth into an appropriate Medicaid program once they are no longer involved with CP&P. NJ FamilyCare, New Jersey's Medicaid program, offers more robust coverage services than MEYA for certain eligible populations such as pregnant women, disabled individuals, and adults without dependent children who are in need of intensive substance use or mental health services and OCS works with DMAHS to identify former foster youth who may also be part of one of these NJ FamilyCare populations, and provide education and support for those youth who may benefit from enrollment in an NJ FamilyCare program over MEYA. Certain NJ FamilyCare programs supersede MEYA enrollment, and OCS works with DMAHS and DCP&P to ensure NJ FamilyCare enrollment for those youth is made as seamlessly as possible. Through these coordinated efforts, the state has continued to consistently achieve 99-100% compliance with ensuring youth aging out of the Child Welfare system have access to medical coverage, with the only evident barriers being youth who actively refuse the MEYA service, or youth who remain ineligible.

The Child Health Units continue to train CP&P staff on recognizing pediatric health "red flags", using the enhanced Pediatric Health and Red Flags Tool developed in 2012 and completed in 2014. The final section of the tool, specific to Adolescents and Young Adults, was accepted in April 2014, and a training module on the Adolescent tool was provided in the Summer of 2014.

Conclusion

DCF continues to recognize the importance of ensuring that the basic medical and behavioral health care needs of all children are met. The Department recognizes this will

require ongoing evaluation to incorporate necessary changes to the infrastructure. As part of this process, DCF has already strengthened its infrastructure, which included early changes around case practice and collaboration and more recently changes in areas related to addressing trauma and enhancing service provision. Since the restructuring of DCF's health care delivery system and the release of the Coordinated Health Care Plan, service delivery and physical and behavioral health care outcomes for children in out-of-home placement have improved. The work, partnerships and reorganization outlined in this plan will inform and drive health care oversight and coordination for DCF.