



# HEALTH CARE OVERSIGHT AND COORDINATION PLAN

Nebraska Department of Health and Human Services  
Division of Children and Family Services  
2015-2019 Child and Family Services Plan

Department of Health & Human Services



## *Nebraska Health Care Oversight and Coordination Plan*

For the 2015-2019 DCFSP submission, states must provide a new Health Care Oversight and Coordination Plan. The new plan should reflect lessons learned since development of the prior plan and continue to strengthen activities to improve the health care and oversight of children and youth in foster care over the next five years

Section 422(b)(15)(A) of the Act requires states to develop a plan for the ongoing oversight and coordination of health care services for children in foster care. States must develop the plan in coordination with the state title XIX (Medicaid) agency, and in consultation with pediatricians and other experts in health care, and experts in and recipients of child welfare services.

The Health Care Oversight and Coordination Plan must include an outline of all of the items listed below, enumerated in statute at section 422(b)(15)(A)(i)- (vii) of the Act:

- A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
- How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home;
- How medical information will be updated and appropriately shared, which may include developing and implementing an electronic health record;
- Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care;
- The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;
- How the state actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children; and
- Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.

## **HEALTH CARE SERVICES 2015-2019**

The optimal health of all children is best achieved with access to appropriate and comprehensive health care benefits that encompass medical care, preventative care, critical care, behavioral health services, oral and vision health.

The Division of Children and Family Services has an organized Healthcare Oversight Team. The purpose of this team is to share information and provide recommendations to assure ongoing oversight and coordination of health care services for children who are in the care and custody of DCFS. The team meets to review existing programs, policies and efforts; identify gaps; and make recommendations for enhancements with special attention to the collaboration, coordination, and accessibility of medical and mental health services for children.

The Healthcare Oversight Team began as an internal group in 2013 and in 2014 expanded to include representatives outside of DHHS. Various Divisions of the Department of Health and Human Services are members of this team as DCFS recognizes the importance of collaboration to ensure success of the continuity of care for children in the care and custody of DCFS. All team members represent an entity directly related to the children served by DCFS and are vital to the success of the team goals. The current team members are:

- Child and Adolescent Psychiatrist-Beth Ann Brooks, MD
- Pediatrician- Tina Scott-Mordhorst, MD
- Youth Consumer-Mickey Alder, former foster child
- Foster Parent-Joan Schwan, foster parent for 25 years
- Division of Development Disabilities Representative-Stacey Waldron, Psychologist
- Division of Medicaid and Long-Term Care Representatives-Cindy Buesing, Behavioral Health Program Specialist; Lori Lewis, Program Specialist; Lisa DeVries, Pharmacy Consultant; Abby Anderson, Pharmacy Program Specialist
- Division of Public Health Representative-Jenifer Roberts-Johnson, Deputy Director
- Division of Children and Family Services Representatives-Alyson Goedken, Administrator
- Division of Behavioral Health Representatives-Blaine Shafer, MD, Chief Clinical Officer; Sheri Dawson, Deputy Director, RN

The Healthcare Oversight Team meets every other month in effort to finalize the strategic plan and achieve the identified team goals. The goals of the Healthcare Oversight Team:

- Health Care Services should be simple to understand, easy to find and accessible to all
- Create a coordinated health care initiative across all DHHS Divisions along with community partners

#### Strategies:

- Ease, logic and common language for informative publications
- Face to face discussion with consumers
- Have online and telephone resource options
- All youth consumers have access to a medical home
- Create a educational profile for foster children
- Collaboration with providers and consumers
- Coordinate with Nebraska Public Health Departments for Prevention and Education resources

#### Challenges:

- Inconsistent, inaccessible and non-ease use of technology
- Public accessibility
- Medical home accessibility for foster children
- Primary care providers not accepting Medicaid
- Compliance by consumers (no shows to appointments)
- Coordinating efforts among various entities

The Healthcare Oversight team will decide on action steps to achieve the identified strategies and goals. The team will work toward connecting all entities involved in creating a continuity of care and maintaining or establishing medical homes for all youth in DCFS custody. Coordinating among all Divisions within the Department of Health and Human Services along with the managed care organizations, parents, foster parents, physicians and therapist, the goal to create and maintain quality health care access and continuity is achievable.

Medical services are available to all state wards and to those parents or families of wards who meet Medicaid eligibility requirements. Nebraska policy authorizes DHHS to make all decisions around medical treatment for children in state care, a court order may alter this authorization. All medical services provided to children must be based on a comprehensive assessment of the child's needs. The Children and Family Services Specialist (CFSS) is responsible for developing a case plan that reflects the needs identified in the assessments and ensure all necessary services are implemented. Regulations include instructions for involvement and consultation when specific issues arise and encourage the CFSS to involve parents in the medical decision-making process. Additionally, policy mandates the CFSS consent to any necessary emergency medical treatment for a child, except as restricted by the court. Ultimately, the CFSS is responsible for providing or arranging medical services, and parents are responsible to the extent possible for payment of the medical services provided if the family or child is not determined to be Medicaid eligible.

Parents and CFSS work together to ensure children who remain in the home receive medical care. An initial examination is not required, but the CFSS can request a physical examination if health concerns exist. All children receive ongoing medical care as necessary throughout the time they work with DCFS, and parents are responsible for scheduling and maintaining all routine, recommended, or follow-up medical appointments for children.

For children who have been removed from their home of origin, DCFS has three distinct roles: a custodian, a guardian and to initiate referrals for evaluations. As the custodian, DCFS secures and supervises a temporary placement and will consent to any necessary emergency medical, psychological or psychiatric treatment for the child. Guardian is assumed if the court has given the care and custody of a child to DCFS or parental rights are not intact. For the duration of the court ordered custody, DCFS is authorized to make all decisions about medical and psychological treatment. Once a placement has been located, it is the responsibility of the CFSS to share information with the temporary care provider regarding the child's behavior, history, specific needs and the child's case plan. Other CFSS responsibilities include; providing coordinated services to the child and family, to provide support services to the caregiver, and to provide relevant information and notice of placement to schools, medical providers and therapists and document activities and decisions.

DCFS Supervisors play a vital role in the support of the CFSS. The main responsibility of the DCFS Supervisor is to provide consultation and support to the CFSS and to assure families are receiving consistent case management during out of home placement.

The responsibility of the temporary caregivers is to communicate and work cooperatively as a team member with the CFSS, parents and service providers to reach the goals of the case plan. Additionally, the temporary caregivers are to arrange and secure routine and emergency medical care and treatment for the child in their care and advise the CFSS of such efforts. For continuity of care, the caregiver will use the medical provider identified by the parents or the CFSS. Under the guidance of the CFSS, the caregiver will acquire specific care and treatment for the child such as medical or psychological appointments or treatment. Caregivers are to provide written documentation to the CFSS regarding the child's progress. It is recommended that the parent from which the child was removed be present at all medical appointments, unless the parent's presence would not be in the best interest of the child.

Children who are removed from their home of origin are to receive an initial physical examination within 14 days of placement, and annually thereafter. Children also receive ongoing medical care outside of annual examinations as necessary. Children in out-of-home placement have annual dental exams. For continuity of medical care, if a child has a primary physician when entering care, DCFS makes every effort to use this provider.

In addition to the medical care expectations identified for children who remain in their home of origin and the children who are removed, Nebraska has identified a schedule for health screenings and collaborates with the Division of Medicaid and Long-Term (MLTC) care who administers the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT), also known as the Nebraska Health Check. The Physical Health Managed Care companies who are contracted through MLTC also use the EPSDT schedule which enhances the ability of all who help care for children know the correct sequence for health screenings to take place.

The EPSDT program is required to provide screening exams, vision, hearing and dental services in addition to other necessary health care to those under 21 years of age on a schedule that is reflective of accepted medical and dental standards. The "Recommendations for Preventive

Pediatric Health Care” periodicity schedule established by the American Academy of Pediatrics is used and is outlined below:

- Birth
- 3 weeks
- 2 months
- 4 months
- 6 months
- 9 months
- 1 year
- 15 months
- 18 months
- 2 years old and every year following until age 6
- Every year or every other year after age 6 to ensure proper health care maintenance and required immunizations
- Health Checks are to be offered if determined to be medically necessary by the provider

And the American Dental Association periodicity schedule:

- Initial exam at age 1
- Every 6 months thereafter

The Division of Medicaid and Long-Term Care are members of the Healthcare Oversight Team and work directly with the managed care companies. Their participation on this team is vital to ensure the coordination, continuity, and access of medical care for children is achieved. This managed health care delivery system offers an opportunity for access to a PCP, coordination of medical care and emphasizes preventive care and encourages the appropriate utilization of services.

The Physical Health Managed Care system offers an opportunity to assure access to a PCP, coordination of medical care, emphasizes preventive care, and encourages the appropriate utilization of services.

A June 6, 2012 Administrative Memo #15-2012; explaining the enrollment of State Wards in the Nebraska Medicaid Physical Health Managed Care. The DCFS Specialist was notified about the requirements of a Medicaid eligible state ward child to be enrolled into managed care and the importance of continuity of care for the child in keeping their primary care physician, or if not available, the importance of working with the family and child to determine an appropriate choice. Training and other helpful information was communicated to the Specialist about physical health managed care through this memo.

Physical Health Managed Care was implemented statewide July 2010

Services include:
• Inpatient Hospital services
• Outpatient Hospital services
• Medical Laboratory and X-ray services
• HEALTH CHECK (EPSDT) services for children under the age of 21
• Physician services including nurse practitioner, certified nurse midwife, physician assistant, and
• Anesthesia services.
Examples of Physician services are:
• Prenatal and Maternity care
• Routine office visits
• Specialty consultations and/or treatment
• Physician administered medications
• Home Health services
• Private Duty Nursing services
• Therapy services (e.g. physical, occupational, and speech pathology therapies, and audiology)
• Medical equipment and medical supplies including hearing aids, orthotics, prosthetics, and
• nutritional supplements
• Podiatry services
• Chiropractic services
• Ambulance services
• Vision services
• Skilled Care
• Family Planning services
Services provided at a Federally Qualified Health Center (FQHC)
• Well-Child Care & Immunizations
• Women's Health Exams
• Primary Health Care
• Urgent Care
• Family Planning
• WIC
• Breast & Cervical Cancer Screening
• School & Sports Physical Exams
• Minor Surgical Procedures
• Interpretation Services
• Women's Health Education
• Pregnancy Testing & Counseling
• STD Checks & Education
• Anonymous HIV Testing
• Laboratory Testing
• Diabetic Education
• Referrals for Specialty Care
• Nutrition Counseling
• Referrals to Community Services
• or Rural Health Clinic (RHC)
• Birthing Centers

While providers have an essential role in the continuity and consistency of medical care for children in the care and custody of DCFS, ultimately DCFS is responsible to ensure health and safety for all children. It is the responsibility of the CFSS to assure child safety and needs are being met, Nebraska utilizes Structured Decision Making™ (SDM) to assess the safety and risk of future maltreatment for all accepted child abuse and neglect intakes. Objective assessment procedures are utilized by the CFSS at major case decision points from intake to case closure to aid in and support critical decisions. SDM targets agency services to children and families at high risk of maltreatment and helps ensure that service plans reflect the strengths and needs of families. SDM increases the consistency and validity of case decisions, reduces subsequent child maltreatment, and expedites permanency. The SDM risk assessment includes a characteristic section which allows the CFSS to evaluate and document the child's health needs and to communicate and corroborate with medical personnel. The family strengths and needs assessment allows the CFSS to gain knowledge and background information regarding the physical health, mental health and medications of both the parents and their children. This is a vital part of case planning to aid in the identification of appropriate goals, strategies, services and resources for familial success.

In effort to complete the required SDM assessment tools, the CFSS meets regularly (minimally one time each month) with the child, parents, and caregivers. Regular and frequent visits with the child, foster family, and biological family provides the opportunity for the CFSS to identify and assess the medical, mental health, substance abuse, behavioral health needs, services and the progress and frequency of the services. The application of the family strengths and needs assessment, reviewing progress on the case plan, and the usage of 'required contact template' are methods for CFSS to aid in the identification and assessment of a child's needs. The CFSS documents all illnesses and symptoms, medical appointments and the doctor who provided care along with all prescribed medications.

The completed SDM assessments and narratives written by the CFSS provide data to monitor, plan, and evaluate the assessment of child and familial needs and service delivery. To assist in data collection, DCFS evaluates SDM model fidelity and completes case reviews related to CFSR outcomes. The CFSR case review results for items 17-23 provide data as to the frequency and quality of CFSS assessments of child and familial medical and mental health needs.

The results of the case reviews conducted are provided to staff in multiple ways as a part of the Continuous Quality Improvement system in Nebraska. This improves the performance and adherence not only to the SDM model but the quality of work completed by CFSS. The Continuous Quality Improvement (CQI), which is the Department's Quality Assurance model system, is used to assess child welfare practice, outcomes and compliance and uses its data to guide and change policies and practices in order to ensure that children and families receive quality services. CQI is constant learning about practice and outcomes, not simply quality assurance or compliance.

The data collected through the CQI process and case reads is obtained through the statewide child welfare automated system, N-FOCUS. Specifically, N-FOCUS is the location where CFSS workers enter all contact narratives and SDM assessments. Additionally, fields are built into N-FOCUS to capture medical, dental and mental health appointments along with identifying the

physician providing care. N-FOCUS will be used as the data source for which information will be generated to measure the consistency children's medical and mental health needs are assessed and services are provided. In addition to how the N-FOCUS system is used for CQI purposes, below are additional examples of how N-FOCUS is used to monitor medical and mental health services:

- N-FOCUS interfaces with the Medicaid Managed Information System (MMIS). MMIS uses data from fee for service claims and managed care encounters to produce Early & Periodic Screening/Diagnosis/Treatment-related reports and generates related correspondence. This helps facilitate comprehensive, preventative health care and early detection and treatment of health problems in Medicaid eligible children by sending outreach letters to EPSDT-Medicaid eligible clients.
- CFSS workers are required to scan the following information into the N-FOCUS document imaging field: EPSDT reports, home health reports, nurse, physician and hospital documentation, dental and vision reports and physical exam results and reports.
- The initial and follow up contacts with the child and parent regarding the child's medical history is documented in a narrative, along with the child's physical, vision, dental and psychological appointments and results. In addition to the narrative, N-FOCUS has specific fields to capture actual dates of appointments.
- N-FOCUS can send reminders to CFSS workers to alert the yearly physical, dental, and vision exams for state wards are due. N-Focus has the ability to send alerts to display 60 days and 30 days before the one-year anniversary of the last exam date entered, these alerts help the CFSS make certain the health exams stay current.

To emphasize the importance of documenting information into N-FOCUS, Administrative Memo #6-6-17-05, was issued to address the guidelines of Health, Dental and Mental Health Examinations on N-FOCUS. The dates of health, dental, vision and psychological evaluations will be entered into the system. This will create alerts for the DCFS Specialist with a reminder exam appointments are due. Additionally, this documentation allows the Supervisor to monitor and review cases to discuss with the Specialist the importance of children receiving regular and timely, health, vision, dental and mental health care for their well-being.

Additionally, Administrative Memo #9-2011, outlines Dental Health Resources and emphasizes the importance dental health needs for children are met. Programs and resources are described and information is provided on how to access the programs.

The Healthcare Oversight team has discussed updating the frequency of dental health exams to every 6 months instead of the current annual dental appointment schedule. In order to communicate and educate the DCFS workforce on this change, an Administrative Memo will be created to update this policy. Once the Administrative Memo is written and distributed to the field, the new practice will be integrated into new worker training and reinforced during supervision. DCFS reached out to the Divisions of Public Health and MLTC to update dental resources and will collaboratively identify and determine what oral health programs will benefit

children in the care and custody of DCFS. An update to the Dental Health Resources Administrative memo will reflect this information.

Most recently, Administrative memo # 5-2014; regarding document imaging for DCFS and Foster Care files was released. This memo gave direction on N-FOCUS categories and documents be imaged into N-FOCUS that relate to all documents for DCFS, as well as documents to be maintained in a hard copy file.

DCFS presents health care data to staff at the monthly DCFS Operations and CQI meeting. The data showing the Physical Health of the child, CFSR item 22 and Mental and Behavioral Health of children, CFSR item 23, reflect whether or not DCFS has sufficiently assessed these needs and if efforts were made to ensure appropriate services were provided. CFS Service Area's provide feedback on how to improve the physical and behavioral health outcomes for children. Suggestions received pertain to the N-FOCUS system. These included; updates for documenting appointment dates, current providers, treatment plans, medication lists, allergies to improve the process to electronically update this health information. Another suggestion included the generation of monthly reports to monitor the dates a physical or EPSDT was completed in order to better identify barriers to achieving the goals of providing appropriate services for health conditions.

The systematic CQI process is robust on a statewide level and within each local jurisdiction. The data is reviewed monthly; which leads to the identification of strengths and barriers within the field at achieving the desired outcomes. Throughout this process, the most significant and prevalent barrier to success is the lack of quality documentation. The data will continue to be provided on a monthly basis in effort to monitor the progress of the identification and assessment of a child's needs. Future collaboration with our CFS Service Area's and the N-FOCUS business team will be coordinated to improve the process to update, coordinate and communicate the health needs of children in DHHS care and custody.

DCFS has made concerted efforts to address the medical and mental health needs of children served by CFS. In addition to DCFS initiatives, the Nebraska Legislature has taken steps to improve health care access and services for children in DCFS custody. The 2013 Legislative session included the passage of LB269; this bill updated the provision relating to DHHS and any association providing care for a state ward, to be responsible for applying for any health insurance available to the juvenile including but not limited to Medicaid. Proposed plans for the care, placement, services and permanency provided to the juvenile shall include a statement regarding eligibility of the juvenile for health insurance, including, but not limited to, Medicaid. When the plan includes the provision of services in order that the juvenile can remain in his/her home and such services are to prevent out-of-home placement, the plan shall be prepared and shall clearly state the services described in the plan are to prevent placement and that, absent preventive services, foster care is the planned arrangement for the child.

This same bill requires beginning January 1, 2014, Medicaid coverage may be provided for individuals under 26 years of age (former foster care youth). Written independent living transition proposals shall include the child's potential eligibility for Medicaid coverage. In addition to DHHS's current requirement of providing the child a certified copy of the birth

certificate before they are 19 years of age, DHHS shall also provide all documentation required for enrollment in Medicaid for former foster care children.

DHHS has taken steps to ensure that children's health needs are met when aging out of foster care. The Nebraska Legislature passed LB216 in the 2013 Legislative session with an update in the 2014 Legislative session, known as Bridge to Independence. This bill is to support former state wards in transitioning to adulthood, to become self-sufficient, and to create permanent relationships. This extended services program shall at all times recognize and respect the autonomy of the young adult. Moreover, there is a transition plan relating to the health care needs of children aging out of foster care by extending services and support provided under this program which include and are not limited to: Medical care under the medical assistance program, obtaining appropriate community resources, including; health, mental health, developmental disability and other disability services and supports and to access pregnancy and parenting resources and services. To create a health care power of attorney as required by the federal Patient Protection and Affordable Care Act.

Medical and physical care are only two components of a child's health care services. Mental health is a key factor in a child's healthy development; children need to be healthy in order to learn, grow and lead productive lives. Nebraska has taken steps to expand the behavioral health system to comprehensively meet the needs of children who have entered the system.

The Division of Medicaid and Long-Term Care and Magellan Behavioral Health of Nebraska have a managed care contract for Medicaid-funded behavioral health services. The following supports are available:

- Telehealth and Magellan Connect (smartphone) services are available for members. In addition, a PCP assistance line is offered as a resource, and Magellan is making behavioral health practice guidelines available to PCPs for the most common mental health conditions seen in primary care.
- Practice Wise is a tool for providers serving children and adolescents, to research best practices, to track progress and to guide treatment for the most common disorders, along with providing tools for children and parents.
- The Whole Health Rx program works with providers on a medication adherence program.
- MY LIFE (Magellan Youth Leaders Inspiring Future Empowerment) is a program to empower youth to have a voice in the direction of their own treatment and life, as well as to have youth who are in recovery or on the road to recovery serve as models for other youth needing assistance.
- Magellan participates in discussions with all three physical health managed care organizations regarding Medicaid members with co-morbid mental health and physical health issues. Discussions continue with provider organizations on integrating physical health and mental health treatment.
- Magellan has published a monograph, "Appropriate Use of Psychotropic Drugs in Children and Adolescents," that provides guidelines for prescribing practices, FDA approval and age guidance, and black box warnings.

The goal of this managed care system is to provide services consistent with best practices that will decrease reliance on emergency and inpatient levels of care and increase the use of evidence-based treatment to increase outcome driven community based programming and support that increases coordination between service providers.

Behavioral Health services covered by Nebraska Medicaid and Magellan of Nebraska:

- Crisis Services for assessment and outpatient services when treatment is needed.
- The Client Assistance Program (CAP), a meeting with a therapist to deal with a general problem happening in your life, this is five outpatient therapy sessions per year without having to be prior approved.
- Assessment/Diagnostic Interviews/Psychological Testing.
- Outpatient therapy.
- Inpatient services for mental health problems and in home psychiatric nursing services.

Through the behavioral health managed care contract special services for children are offered by Magellan of Nebraska:

Evidence Based Practices:

- Parent Child Interaction Therapy (PCIT). PCIT focuses on children age 2-12. It helps to improve the quality of the parent-child relationship. PCIT treats disruptive behaviors.
- Child-Parent Psychotherapy (CPP). CPP focuses on children from birth to age 5 who have lived through at least one traumatic event. CPP works with the child and his or her parent (or caregiver) to restore the child's sense of safety and attachment.

Other Supportive Services:

- In-Home Family treatment services.
- Community Treatment Aide services provided at home or school.
- Conference can include treatment staff, family and others.
- Intensive Outpatient services offer individual, family and group therapy in the home or in the office, to treat mental health or substance use problems.
- Psychiatric Residential Treatment Facilities, for children who have serious mental health and/or substance abuse issues.
- Therapeutic Group Homes, helps children feel better, find new friends and do better at home, school and work.
- Professional Resource Family Care. Children and adolescents get individual and family treatment for mental health and substance use issues.

Through the managed care contract, efforts continue to create continuity of health care services, services that are beneficial for the health of children and oversight of prescription medications for all children across Nebraska.

Collaborating with Child Advocacy Centers in another avenue utilized by DCFS to meet the mental health needs of children. This collaboration will provide an opportunity for the delivery of holistic, coordinated and trauma informed response to children and families. The treatment

team consisting of the DCFS Specialist and a cooperating pediatrician from an appropriate CAC will assure that all child abuse or neglect related injuries are identified.

The CAC Advocate works closely with the every child and caregiver to assess the need for mental health therapy. This typically occurs the day the child is interviewed at the CAC. All Nebraska CACs have linkage agreements with local mental health therapists who specialize in trauma focused therapies. These therapists conduct detailed trauma assessments utilizing tools such as The Child Sexual Behavior Inventory, The Child PTSD Symptom Scale, Moods and Feelings Questionnaire, Pediatric Symptom Checklist, SCARED Brief Version, Trauma Symptom Checklist for Children, Trauma Symptom Checklist for Young Children, and The UCLA PTSD Reaction Index for DSM-IV. The therapists identified through the CAC advocate have training in the following evidenced based practices—Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Alternatives for Families Cognitive Behavior Therapy (AF-CBT), Parent-Child Interaction Therapy (PCIT).

The Omaha CAC has an on-site mental health practitioner. This therapist provides CFTSI (Child and Family Traumatic Stress Intervention) therapy to clients ages 7 through 18 years. The therapist uses the Trauma History Screen and Child PTSD Symptom Scale; youth who qualify for services are provided treatment at the child advocacy center. Most clients are screened same day or within 24-48 hours of their visit to the CAC. The CAC's Advocates and Therapist are involved in referring clients to other appropriate mental health services in the community.

The importance of collaboration with our Child Advocacy Centers will be conveyed to the CFSS.

To further promote healthy children, DCFS recognizes the vitality of being a trauma informed organization. In collaboration with other DHHS Divisions, DCFS is the current practice of knowledge, education, and the assessment of the impact of trauma on a child. A Trauma Informed kickoff conference, "Trauma Across the Lifespan", was held in 2013. This conference solidified the thinking that trauma can have a huge impact in a child's well-being and additional work must be done to screen and train in this area.

Collaboration continues within the Divisions of Children and Family Services, Behavioral Health, Public Health and Developmental Disabilities. A Trauma 101 curriculum is being reviewed and updated for each Divisions for training in the area of trauma for staff, service providers, foster care providers and interested community members. A DCFS Program Specialist and the DCFS Training Administrator are Trauma 101 Trainers and the DCFS Training Administrator sends monthly updates to staff on the subject of vicarious trauma and compassion fatigue.

The Children's Bureau has approved a Training and Technical Assistance request submitted by Nebraska to learn about worker, provider and foster parent knowledge of trauma informed care. This will inform the development of a plan. The National Resource Center for Organizational Improvement is working with Nebraska regarding this project. This process includes conducting an assessment survey of DCFS staff, child welfare service providers and foster families for feedback regarding their current knowledge of trauma informed care. The information generated from the surveys will be utilized to create a work plan that will guide the development of a

strategic plan. This strategic plan is for the realization of a Trauma Informed System within the Nebraska Department of Health and Human Services. The strategic plan will have a 5 year focus and will begin in September 2014.

DCFS is also involved with the Systems of Care (SOC) planning grant with the Division of Behavioral Health. SOC assist in creating goals and identifying resources relating to trauma services for families across Nebraska.

CFS has implemented new training resources titled “Mental Health Problems” for our CFS Specialists that include information about the Adverse Childhood Experiences (ACE) study, which demonstrates long-term consequences in adulthood of multiple adverse experiences that occur in childhood. Another resource was developed that defines and explains the different evidence-based child and adolescent psychosocial interventions to guide the CFSS and family to develop appropriate service plans to guide and monitor identified health needs.

The Healthcare Oversight team is also working to meet the recommendations of the Nebraska Children’s Commission for the management of psychotropic medication for children in foster care. These recommendations include:

- Identify the parties empowered to consent for treatment for youth in state custody in a timely fashion.
- Establish a mechanism to obtain assent for psychotropic medication management from minors when possible.
- Make available simply written psychoeducational materials and medication information sheets to facilitate the consent and assent process.
- Establish training requirements for child welfare, and/or foster parents to help them become more effective advocates for children and adolescents in their custody. This training should include the names and indications for use of commonly prescribed psychotropic medications, monitoring for medication effectiveness and side effects, and maintaining medication logs. Materials for this training should include a written “Guide to Psychotropic Medications” that includes many of the basic guidelines reviewed in the psychotropic medication training curriculum.
- DHHS should design and implement effective oversight procedures that:
  - Establish guidelines for the use of psychotropic medications for youth in state custody.
  - Establish a program, administered by child and adolescent psychiatrists, to oversee the utilization of medications for youth in state custody. This program would:
    - Establish an advisory committee (composed of agency and community child and adolescent psychiatrists, pediatricians, other mental health providers, consulting clinical pharmacists, family advocates or parents, youth involved in the child welfare system and state child advocates) to oversee a medication

formulary and provide medication monitoring guidelines to practitioners who treat children in the child welfare system.

- Monitor the rate and types of psychotropic medication usage and the rate of adverse reactions among youth in state custody.
  - Establish a process to review non-standard, unusual, PRN, and/or experimental psychiatric interventions with children who are in state custody.
  - Establish a process to review all psychotropic medication usage for children five and under.
- Collect and analyze data and make quarterly reports to the state child welfare agency regarding the rates and types of psychotropic medication use. Make this data available to clinicians in the state to improve the quality of care provided.
    - Maintain an ongoing record of diagnoses, height and weight, allergies, medical history, ongoing medical problem list, psychotropic medications, and adverse medication reactions that are easily available to treating clinicians 24 hours a day.
  - DHHS should design a consultation program administered by child and adolescent psychiatrists. This consultation service should provide face to face evaluations when possible, or by telepsychiatry in remote areas. The service will address the following:
    - Provides consultation by child and adolescent psychiatrists to the persons or agency that is responsible for consenting for treatment with psychotropic medications.
    - Provides consultations by child and adolescent psychiatrists to, and at the request of, treatment providers treating this difficult patient population.
    - Conducts evaluations of youth by child and adolescent psychiatrists at the request of the child welfare agency, the juvenile court, or other state agencies empowered by law to consent for treatment with psychotropic medications when concerns have been raised about the pharmacological regimen.
  - DHHS should create a website to provide ready access for clinicians, foster parents, and other caregivers to pertinent policies and procedures governing psychotropic medication management, psychoeducational materials about psychotropic medications, consent forms, adverse effect rating forms, reports on prescription patterns for psychotropic medications, and links to helpful, accurate, and ethical websites about child and adolescent psychiatric diagnoses and psychotropic medications.
  - DHHS and Administrative Office of the Courts along with other system stakeholders should work together on guidelines and protocols that address the principles and recommendations set forth in this document.

A member of the Healthcare Oversight Team, a contracted psychiatrist, will provide psychiatric case review and consultation at the request of DCFS for children and youth in custody. The psychiatrist has collaborated with treatment providers and other medical professionals concerning the usage, prescribing practices and the current process of prescribing psychotropic medications to children in DCFS custody. Additionally, data will be collected to analyze the number of children who are prescribed more than two psychotropic medications and case reviews will occur for the identified children. The current processes and procedures are being

assessed. The Healthcare Oversight Team will collaborate to identify specific goals and actions step necessary to achieve the recommendations stated above.

Currently, the Children and Family Services Specialist (CFSS), authorizes, monitors and oversees the use of psychotropic medications by youth in DHHS custody. The CFSS receives a consent request from pediatricians, physicians, and psychiatrists to prescribe, change medications, or change dosages for children receiving psychotropic medications. The CFSS in consultation with parents, foster parents, and family teams makes a decision regarding whether the medication is in the child's best interest. DCFS requires and provides training for the CFSS for managing psychotropic medications and informed consent. The psychotropic medication training encourages CFSS to ask the prescribing physician questions about the reasons for the medication, risks and common side-effects and alternatives to the recommended medication. Additionally, this training educates the CFSS about psychotropic medication categories and side-effects. A new policy will be created for Children and Family Service Specialists to consult with medical professionals when questions arise during the informed consent process when psychotropic medications are being prescribed for children in our care.

## **HEALTH CARE SERVICES**

### **Five Year Plan (FY 2014 through FY 2019)**

1. Continue collaboration with the Division of Behavioral Health to develop and implement the Systems of Care (SOC) approach. SOC is designed to meet the needs of children and families by creating a service delivery approach that will evolve as needs and condition change. This involves cross agency coordination of services for child welfare involved children, youth, and families. Agencies work in partnership with families to agree on common goals, values and principles.
  - Develop a shared infrastructure to coordinate efforts toward the goals of safety, permanency and well being
  - Work to ensure the availability of evidence based practices
  - Supports designed to protect families and children from maltreatment while creating well-being and stability
  - Create a seamless connection within state and local services for mental health services for children and families
  
2. Develop a Strategic Plan for a Trauma Informed Care.
  - DHHS Divisions are working together to define our roles and vision for a Trauma Informed System.
  - A request has been completed for Training and Technical Assistance in creating a Trauma Informed Care System.
  - An intra-agency assessment survey will be completed by Children and Family Services Specialists (CFSS); Supervisors; and Administrators in each DCFS Service Area.
  - Contracted Child Welfare Service Providers will be identified in each service area to complete a survey assessment to identify their knowledge and efforts for Trauma Informed Services.

- A Stakeholder meeting to create coordination, collaboration, communication, to promote buy in from our partners.
3. Invest in our Children and Family Service professionals.
    - Provide specialized training to empower staff to effectively communicate with families.
    - Provide Compassion Fatigue/Vicarious Trauma training.
    - Provide training on Medicaid service changes.
  4. Provide appropriate and timely services to children for their physical and mental health needs.
    - Review current policies of when physical/dental/vision and mental health appointments occur
    - Review training on documentation of all health exams
    - Review process of obtaining health information from child's primary care physician and therapist