NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

HEALTHCARE OVERSIGHT AND COORDINATION PLAN 2025-2029

Nebraska Department of Health and Human Services
Division of Children and Family 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)-(viii) 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 for children in care 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;
- The procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses; 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.

The Department of Health and Human Services (DHHS), Division of Children and Family Services (CFS) Healthcare Oversight and Coordination Plan 2025-2029 reflects an outline of the items enumerated in statute in section 422(b)(15)(A) of the Act, completed strategies from the 2020-2024 plan, lessons learned, and new strategies. By employing the strategies detailed within this plan, the Child and Family Services Review (CFSR) Well-Being Outcome 3, *Children receive adequate services to meet their physical and mental health needs,* continues to be addressed.

CFS works collaboratively with other DHHS divisions and external partners to protect vulnerable children from harm and maltreatment by addressing healthcare needs across the state. The CFS Well-Being Team oversees the Health Care Oversight (HCO) Committee and Plan. This plan was developed by the HCO Committee, which includes staff from CFS; the Divisions of Medicaid and Long-Term Care (MLTC), Behavioral Health (BH), and Developmental Disabilities (DD); professionals and stakeholders within the health care and child welfare professions; and people with lived experience.

2020-2024 Completed Strategies

Item 1: A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.

- During the first two weeks of a child's removal from their home, the following occurs:
    - The Child & Family Services Specialist (CFSS) ensures the caregiver arranges for medical care with the child's established primary care provider to preserve the continuity of care. The CFSS is responsible for ensuring the child obtains the necessary medical appointments. If the child is unable to see their primary care provider (such as due to proximity), the CFSS, through the caregiver, will request the new treating provider consult with the child's established primary care provider.
    - A comprehensive assessment is completed, which includes a review of the child's physical, mental, developmental, and dental health.
    - Additional visits occur as needed, to assess the child, monitor the adjustment to care, identify evolving needs, and continue information gathering.
    - Nebraska Medicaid regulations authorize state wards to be screened each time they are placed in a foster home or facility. CFS policy outlines that the initial exam following the youth's removal from their home will occur within the first two weeks.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) exams are provided at least annually for all state wards on Medicaid. Nebraska Medicaid regulations outline the standards for EPSDT exams.
    - These exams have five components:
        1. Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders.
        2. Comprehensive, unclothed physical examination.
        3. Appropriate immunizations in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
        4. Laboratory testing (including blood lead screening appropriate for age and risk factors).
        5. Health education and anticipatory guidance for both the child and caregiver.
- Nebraska's Continuous Quality Improvement (CQI) team tracked data through quarterly case reads in the Nebraska Family On-Line Client User System (N-FOCUS) to confirm if an initial health screening was completed within two weeks of a child's removal from their

home. CFS does well with meeting this item. In 2023, there were only five instances from all the cases reviewed where an EPSDT or initial exam was not completed when the child entered care.

- N-FOCUS sends reminders to the CFSSs to alert them of upcoming due dates for yearly physical, dental, and vision exams for state wards. N-FOCUS also sends alerts 60 days and 30 days before the first anniversary of the last exam entry date. These alerts help CFSSs ensure that health exams are current. Medical information on the youth, such as appointments, reports, and provider information, is kept on N-FOCUS.
- Preventive health care has been provided in accordance with the schedule of well-child visits, immunizations, and related care developed by the American Academy of Pediatrics (AAP) and collaborative professional organizations to meet the unique needs of children in the child welfare system. DHHS emphasizes the importance of following the AAP Periodicity Schedule. In addition to physical health, this schedule addresses developmental, behavioral, and dental health.
- CFS issued a Human Trafficking Standard Work Instruction (SWI) to guide staff on medical checks for youth who went missing from foster care. When youth go missing from care, their health needs are a primary concern. An online tool, Providing Avenues for Victim Empowerment (PAVE), is what CFSSs use to screen youth upon their return from possible trafficking situations to help determine if the youth need a medical exam upon their return.

Item 2: How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home.

- CQI tracked CFSR Items 17 and 18 to ensure the health needs of youth were being met. Item 17 addresses the physical health needs of children, including dental needs. Item 18 addresses the mental/behavioral health needs of children. The Health Care Oversight team reviewed the aggregated data at quarterly meetings, as available. When data showed that needs were not getting met as often as possible, the Health Care Oversight team developed recommended strategies to help CFS improve results. Examples of resulting strategies included requiring the youth's primary care doctor to be entered in N-FOCUS, as it was not a mandatory field at the time. CFS also added that CFSS will start discussions with youth, at least by age 18, about transitioning to a primary care physician from a pediatrician, as suggested by the American Pediatrics Association to the existing Transitional Living Plan (TLP) checklist.
- The Health Care Oversight Committee developed a smaller sub-committee to research and determine if the Structured Decision-Making (SDM) assessments CFS utilizes adequately screen for trauma, exposure to substance use, and exposure to domestic violence. It was determined that the SDM assessments do address these concerns.
- The Health Care Oversight Committee reviewed data tracked by the Quality Assurance (QA) team through the Medical Conditions Quality Assurance Review Tool to more thoroughly ensure youth healthcare needs (such as medications, medical appointments, and diagnosis) were being met and documented in N-FOCUS. This strategy is no longer available because the Medical Conditions Review Tool was time-limited. Once QA determined that conditions were being followed, the use of this tool was discontinued.

Item 3: How medical information for children in care will be updated and appropriately shared, which may include developing and implementing an electronic health record.

- Foster homes provide documentation to CFSSs for medical, dental, and vision checkups as well as any mental health and behavioral needs of the children placed in foster care during the reporting months, as required by contracts between CFS and the Child-Placing Agencies.

- The Health Care Oversight Committee worked with the Division of Public Health to understand knowledge gaps school nurses may have related to the needs of youth in CFS care and provided information for training to address these gaps. Through this training, school nurses learned how to determine if a youth is a state ward and, if so, the importance of sharing medical information with a youth's caregivers and CFS Specialists.
- Explored CFS staff obtaining access to Nebraska's Health Information Exchange (HIE). Hotline staff could check recent medical appointments, hospitalizations, or prescribed medications when relevant to a child abuse/neglect call. Case managers could readily obtain medical information needed during initial assessments and ongoing cases. Thus far, staff obtaining access to the HIE has not been possible. However, this strategy remains on the list of strategies for the next five years, as indicated below.
- Medical information about CFS-involved youth has continued to be provided on an as-needed basis by caregivers and medical providers. Examples of ways in which medical information is shared with involved parties are through court reports, family team meetings, Individual Educational Plan (IEP) Meetings, Cync Health-Nebraska's Health Information Exchange, and the Nebraska Prescription Drug Monitoring Program (PDMP).

Item 4: Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.

- CFS has increased the tracking abilities of medical homes for every child in care by requiring the youth's primary care physician information to be entered into N-FOCUS. This data is required to be entered for court-involved youth at the time the court report is written. In 2023, about 75% of state/tribal wards had a primary care physician listed in N-FOCUS. If a court report was not required for youth during 2023 (such as entering care later in the year or exiting early in the year), a primary care physician was not required to be listed. This strategy has promoted continuity of health care services for youth because when youth leave care, the information is readily available for them.
- The CFSS arranges medical care with the child's medical home to preserve the child's continuity of care. If the child is unable to access their medical home (a reason such as proximity to the provider is too far), the CFSS will request the new medical provider consult with the child's medical home.

Item 5: The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications.

- CFS issued the Oversight of Psychotropic Medication SWI to provide guidance to CFS staff on steps to take when a youth is being considered for or is already taking psychotropic medication.
- The Psychotropic Medication Checklist was issued for CFS staff following input from the HCO Committee, health professionals, people with lived experience, and CFS staff. The checklist includes parent, child, and CFS consent.
- CFS provided education to foster parents and CFS staff on utilizing the Psychotropic Medication Checklist.
- CFS utilized Managed Care Organization (MCO) pharmacists for youth medication reviews.
- CFS staffed youth with the MCOs, Medicaid, and DHHS' Medical Services Director. Psychotropic medications prescribed to the youth are often discussed at these staffings.
- DHHS' Medical Services Directors completed training on common mental health diagnoses and possible treatment options for CFS staff.

Item 6: 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.

- The Health Care Oversight Committee worked with the Nebraska Foster Care Review Office and 1184 team meetings to obtain aggregate data on youth's physical and behavioral/mental health care. Like other outside sources obtained from time to time for review at the Committee meetings, these sources echoed what DHHS data showed related to the medical needs of youth in care. According to the data reviewed, strategies have been developed, as explained throughout this document.
- CFS staff have regularly consulted with the DHHS' Medical Services Director, MCOs, and other DHHS divisions regarding youth, as needed. Staffings occur on an as-needed basis to address the physical, emotional, and behavioral health needs of youth. Generally, staffings occur when youth have extensive medical or mental/behavioral health needs. Meeting invitees typically include Program Specialists and/or Registered Nurses from Medicaid and Long-Term Care, CFS Central Office and field staff, representatives from the youth's Managed Care Organizations, Service Coordinators from the Division of Developmental Disabilities, and DHHS' Medical Services Director.

Item 7: The procedures and protocols the state has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.

- CFS worked with the Nebraska System of Care to compile applicable policies for mental health and developmental disabilities to be accessed by CFSSs.
- CFS staff have been provided education on information to include in mental health assessment referrals so that more applicable assessment recommendations may be received.
- The MCOs and CFS collaborated on training for CFSSs to ensure that youth are placed at appropriate higher levels of care.
- Training has been provided to CFS staff on brain injuries from the Nebraska Brain Injury Alliance, as brain injuries and mental health conditions can have similar symptoms.
- Regular staffings occur between CFS and the MCOs on youth in care. CFS collaborates with MLTC, the MCOs, and other medical professionals to prevent youth from being placed at higher levels of care inappropriately.

Item 8: 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.

- CFS worked to ensure that youth aging out of the child welfare system have more information when transitioning from a pediatric doctor to a general practitioner. The CFSS is required to enter the youth's primary care physician into N-FOCUS to ensure a complete history of medical information may be provided to the youth upon exiting custody.
- CFS completed more specific tracking through the Independent Living Plan Quality Review and Independent Living Plan In-Depth Discharge Reviews and made recommendations as needed. An example of a strategy implemented from a recommendation of the Health Care Oversight Committee is to have Bridge to Independence staff provide information to youth about healthcare power of attorneys and healthcare proxies. While CFSSs do this as well

(through the Transitional Living Plan), having Bridge to Independence staff also discuss this with youth ensures that youth are learning about the information.
- The CFSS works with the youth and others on the team to develop a Transitional Living Plan. CFS issued a SWI in 2021 on this process.

Lessons Learned in 2020-2024
- Some strategies listed above were completed early during the 2020-2024 reporting period. These strategies will be evaluated to ensure they still meet the needs, and adjustments will be made as needed.
- When strategies involve program or policy updates, it can be challenging to update the entire CFS workforce on changes across the state. Continued efforts at training and communication will ensure that CFS staff have the information they need.
- Health and medical-related topics can be complex and challenging for non-medical professionals to understand. Training must be tailored for CFS staff.
- Ongoing work is required to recruit members of the HCO Committee, especially those with lived experience, despite efforts that included compensation and scheduling meetings in the evening.

Strategies for 2025-2029
The following strategies are planned for 2025-2029, as determined by the HCO Committee. Strategies will be revised and added as the reporting period progresses. CFS also anticipates using information gathered from the 2024 Statewide Assessment and the 2025 CFSR to determine if modifications are needed to the Health Care Oversight and Coordination Plan.

Item 1: A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.
- Work with the MCOs to see if the youth's claims data (such as medical appointment dates) may be shared with CFS regularly. The HCO committee initially suggested N-FOCUS interface with MCO claims data. However, N-FOCUS does not have this capability. Meetings between the MCOs, MLTC, and CFS occur every quarter, so more discussion about potentially obtaining claims data from the MCOs will be discussed. The benefit of this strategy would be that CFS staff could cross-reference information as a checks and balances, including new or follow-up appointments, any recent hospitalizations, changes in medical providers, and medications.

Item 2: How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home.
- Provide refresher training to CFS staff on how emotional trauma may manifest in children and the various treatment options available to address trauma. CFS staff receive training on this topic in new worker training, but the refresher will build on what they have learned to support youth with their mental health needs. This training is currently being developed.

Item 3: How medical information will be updated and appropriately shared, which may include developing and implementing an electronic health record.
- Continue exploring if CFS can have access to the HIE to have quick access to the youth's medical data. Hotline staff could check recent medical appointments, hospitalizations, or prescribed medications when relevant to a child abuse/neglect call. Case managers could

readily obtain medical information needed during initial assessments and ongoing cases. If this is not a possibility, alternative options for obtaining medical data will be considered.

Item 4: Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.

- An N-FOCUS reminder will be provided to staff that the youth's dentist and optometrist need to be added, as applicable, when the court report is completed. This strategy was selected to help with the continuity of health care services for youth, particularly when children move often or age out of the system. If N-FOCUS consistently contains the youth's dentist and optometrist information, a record of complete medical information will be available for future placements or upon a youth aging out. This will help with the continuity of health care services. An N-FOCUS change request has been submitted, but the changes have not yet begun.

Item 5: The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications.

- Create a Resource Guide and related training for CFS staff related to physical and mental health procedures so that all health-related guidance is in one central location. The dental, vision, and physical health training and resource guide were developed and shared with CFS staff. Training regarding mental health, including emotional trauma (reference Item 2 above), and the use of psychotropic medications is in the process of being developed.
- Continue to complete clinical staffings to review specific CFS-involved youth's healthcare needs. Meeting invitees typically include MLTC Program Specialists/Registered Nurses, CFS central office and field staff, representatives from the youth's MCOs, Developmental Disabilities Service Coordinators, the DHHS Medical Services Director, and others as needed. This strategy was selected to continue to review youth from a multidisciplinary approach to discuss youth's needs and help the CFSS develop the best plan for continuing to work with the youth and family.

Item 6: 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.

- The HCO Committee continues to review sources of aggregate data at HCO quarterly meetings, as available, to gain input on healthcare related to policy development for DHHS. This strategy was selected so that recommendations from the HCO Committee are data-driven and developed based on the needs of the data.
- Continue to consult with the DHHS Medical Services Director, MCOs, CFS staff, and other DHHS divisions through staffing on youth, as needed. This strategy was chosen to ensure a multidisciplinary approach to discuss the youth's needs and help the CFSS develop the best plan for continuing to work with the youth and family.

Item 7: The procedures and protocols the state has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.

- Monthly meetings occur between CFS, MLTC, and the Divisions of Developmental Disabilities and Behavioral Health to discuss system issues that may affect a youth's care. This strategy was selected to continue to discuss system-wide issues that affect youth and

families involved in CFS and sister Divisions and problem-solve ways to streamline involvement within DHHS.

Item 8: 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.

- Bridge to Independence (B2i) staff will include information related to health insurance, healthcare power of attorney, and healthcare proxy in their opening program packets. B2i staff will discuss the items with the youth. This is a newer strategy and will continue to be monitored. Follow-up will be completed with B2i staff to determine the effectiveness of this new strategy and if quality assurance reports show improved outcomes.

Over the last five years, the HCO Committee has recommended many strategies to address Nebraska children's health needs. As detailed above, many of these suggested strategies have been implemented by CFS. New strategies for this reporting period are already in progress, and more strategies will be added as needed. The lessons learned from the last five years will also be addressed.