HEALTH CARE OVERSIGHT AND COORDINATION PLAN (FFY 2025 – FFY 2029)

The DCF Health Care Oversight and Coordination Plan builds upon and revises previously submitted plans. The Department continues to strengthen its efforts to ensure that children in the care and custody of the Department receive routine health care and that their specialized medical needs are addressed. These efforts have included increased collaboration with other state agencies and the medical community, as well as working toward enhanced integration of medical and behavioral health care.

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

In 1998, the Department established a directive that all children in DCF custody receive an initial medical screening examination within seven days of placement and a comprehensive medical examination within 30 days of entering out of home placement.

This directive was subsequently formalized in agency policy. The policy provides greater detail about the role of the social worker, foster parent, and healthcare providers in scheduling, coordinating, and communicating the findings. This policy also specifies that all children in DCF custody receive healthcare in accordance with the American Academy of Pediatrics periodicity schedule. The policy is reviewed with new social workers during pre-service training and is posted on the DCF intranet.

To address the barriers and challenges of making sure that children in placement receive their health screenings, a Task Force on Medical Services was convened in 2014. Led by Dr. Linda Sagor, then a pediatric consultant to the department, and Statewide Medical Social Worker Specialist, the agency's only medical social worker, the task force included ongoing social workers, adoption specialists, managers, foster parents and nurses. After meeting for three months, the Task Force presented nine recommendations to the Department leadership. The recommendations are listed below, along with updated information about implementation as of June 2025.

1. **The importance of trauma-informed medical care and compliance with the DCF medical examination policy should be communicated in all forums --** all staff and foster parent trainings, area office meetings, statewide managers meetings, and in work with community providers. The message should be clear and strong: the Commissioner and senior leadership agree that ensuring that all children in DCF custody have access to consistent and timely health care that meets all their medical needs is consistent with the core values and mission of the Department and is high priority. Monthly statistics should be communicated to managers in their usual management report. Commissioner Miller emphasizes the significance of health and wellness for children in custody and communicates the importance of adhering to medical care policies to the leadership of area offices through regular meetings and communications with leadership and field staff.

2. The current policy (with rigid guidelines for the timing of screening and comprehensive medical visits) should be revisited and updated. Specifically, a system of **triage** might replace the current policy. A triage system would ensure that every child receives the care they need within the *appropriate* time frame (e.g., though some children would require screening within 24-48 hours, others would have a month to complete the screen; the comprehensive exam would be pushed out to 45-60 days if no need to follow-up sooner found on screening exam). An example of such a triage system is attached (Appendix E). A triage system would require that DCF have current medical information on *every* child as soon as (but no later than 24 hours after) they enter placement. This system would require additional nursing resources to implement (as per Recommendation #2) and continued work with community medical providers to ensure timely access. The policy has not changed at this time. With the help of the medical social workers, the area office social workers ensure that children who need to be seen urgently are scheduled and brought to visits promptly. If they have any questions about a child's medical condition, they can always consult with the Medical Director and their Regional Nurse.

3. Efforts to **promote collaboration between the medical community and DCF** are essential. Strengthening this relationship would promote greater understanding of each other's cultures and lead to a commitment among medical providers to understand the medical/psychiatric issues of children in foster care, to provide trauma-focused care, and to allow ready access for medical visits in their offices, allowing decreased usage of the Emergency Department for routine care. Improving communication with inter-office meetings, newsletters, and training sessions would be helpful. Consideration should be given to developing an expert panel of primary care and subspecialty doctors to provide consultation on difficult medical cases. In addition, a protocol for ensuring that pediatric child protection specialists are consulted when appropriate would offer support to the department in complex cases of abuse and neglect.

   DCF has worked to strengthen relationships with all hospital-based Child Protection Teams and Foster Care clinics in Massachusetts and surrounding states to keep lines of communication open. Our nurse liaison at Boston Children's Hospital sends a daily update of all children in DCF custody who are hospitalized. DCF's medical director and regional nurses are in close contact with all child protection teams in the state. Medical social workers are available by phone, and local practices use them as primary contacts for area offices to communicate information.

4. **An electronic system of communication from medical offices** and health centers to DCF should be developed so that information can be quickly and reliably transferred. In many offices with an Electronic Health Record system, a health form can be generated and sent via pdf. This would eliminate the current paper passport system, which is outdated and inefficient. The Massachusetts Health Information Highway (HIway) might be utilized for this purpose. Currently, a majority of medical offices in MA have electronic health record systems which generate reports of medical conditions, medications, immunizations, and allergies. These electronic reports have been very useful in getting and documenting medical information for our children in custody. Regional nurses and medical social workers upload medical documentation into the electronic document's sections of iFamilyNet. DCF is exploring a system called "Identity" (Cordata Health Innovations) which facilitates the transfer of important health information between the child welfare agency and medical offices.

   DCF is actively exploring the potential to integrate EPIC, the most common electronic medical record system in MA, into i-FamilyNet. DCF is meeting regularly with UMASS Medical Center to pilot a project connecting the systems so that data regarding visits, diagnoses, allergies, etc., are automatically uploaded into iFamilyNet.

5. There should be **consistency in data collection** and practice among all DCF Regions, starting with gathering medical information on children from parents/caretakers and providers from the beginning of our work with families (not just at the time of taking custody). An example of a valuable form for data collection is attached (Appendix F). DCF medical social workers collect data on all initial screening and comprehensive visits after placement and document visit dates, medical conditions, allergies, medications, and immunizations in iFamilyNet. This information is now available to foster parents on their portal, Foster MA Connect.

6. Additional **education and training** in medical/psychiatric issues should be provided to all DCF staff and substitute caretakers. Consultation about medical issues should be readily available from area office clinicians (RN or Nurse Practitioner). In addition, consideration should be given to initiating public health campaigns, with DCF as the lead, to deal with medical issues of critical importance

   Update: Medical director Dr. Costello and consultant Child and Adolescent Psychiatrist Dr. Wynne Morgan provide regular training for teams. Recent trainings include Safe Sleep Practices, Outcomes for Children of Parents with Substance Use Disorders, Understanding Psychotropic Medications, and Safety around Water for Children on the Autism Spectrum.

Dr. Linda Sagor, Professor of Pediatrics at Chan University of Massachusetts Medical School and a member of the executive board of the National Council on Foster Care Adoption and Kinship Care of the American Academy of Pediatrics, was appointed the first Medical Director. Dr. Sagor stepped down from this position on April 30, 2023, and Dr. Eileen Costello, formerly chief of ambulatory pediatrics at Boston Medical Center and Clinical Professor of Pediatrics at Chobanian and Avidisian School of Medicine at Boston University, was appointed as medical director on May 1, 2023. Dr. Costello's areas of interest/specialty include the care of children with autism and other neurodevelopmental disabilities, children with mental health disorders, and infants and children of parents with substance use disorders.

7. **A policy on psychotropic medication utilization should be developed and implemented.**

Please see update on progress below.

II. How health needs are identified though screenings will be monitored and treated, including emotional trauma associated with child's maltreatment and removal from home

Reports

The Department disseminates three distinct reports to Area Offices to assist social workers in tracking which children have received the initial and comprehensive medical appointments in compliance with DCF policy:

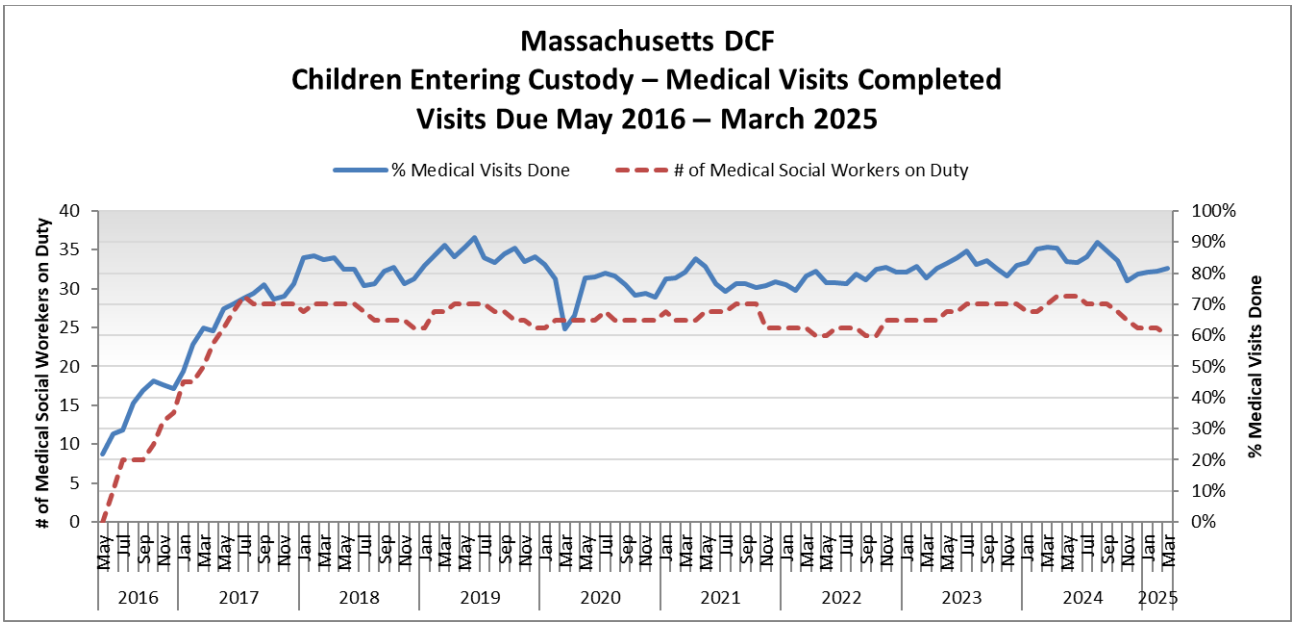
1. A daily Home Removal Episode Report lists all children who have been removed in the previous 24-72 hours and the target dates for their medical visits
2. A Child-Specific report is issued weekly and provides a listing of each child who had a home removal within the last sixty days, whether appropriate examinations were done, and the date it was documented in the electronic case record, iFamilyNet. This report is sorted by Area and Region and includes the unit and social worker assigned to the case.
3. A monthly report of compliance by area office of children seen for the initial and comprehensive visits. This report notes the percentage seen within policy timeframes for initial and comprehensive visits as well as those seen in the 6-8 weeks after placement.

Figure 1. Monthly Medical Visits Report

Monthly Compliance For Medical Screenings Due In March 2025													Run Date: 5/15/2025
Region / Area	**7 Day Medical Visit Due**	**7 Day Medical Visit Done On Time**	**7 Day Medical Visit Done Late**	**% 7 Day Medical Visits Done On Time**	**Total % Of 7 Day Medical Visits Completed**	**30 Day Medical Visit Due**	**30 Day Medical Visit Done On Time**	**30 Day Medical Visit Done Late**	**% 30 Day Medical Visits Done On Time**	**Total % Of 30 Day Medical Visits Completed**	**Total % Of Monthly Visits Completed On Time**	**Total % Of Medical Visits Completed**	**Medical Social Worker Start Date**
Harbor	5	2	2	40.0%	80.0%	0	0	0			40.0%	80.0%	10/1/16
Hyde Park	8	2	6	25.0%	100.0%	6	2	2	33.3%	66.7%	28.6%	85.7%	5/1/20
Jackson Square	10	3	3	30.0%	60.0%	5	1	0	20.0%	20.0%	26.7%	46.7%	2/1/20
Park St.	7	1	0	14.3%	14.3%	9	2	0	22.2%	22.2%	18.8%	18.8%	
Boston Region	**30**	**8**	**11**	**26.7%**	**63.3%**	**20**	**5**	**2**	**25.0%**	**35.0%**	**26.0%**	**52.0%**	
Framingham	14	10	4	71.4%	100.0%	10	5	5	50.0%	100.0%	62.5%	100.0%	11/1/24
North Central	11	9	2	81.8%	100.0%	3	2	1	66.7%	100.0%	78.6%	100.0%	6/1/16
South Central	15	12	3	80.0%	100.0%	12	9	3	75.0%	100.0%	77.8%	100.0%	6/1/16
Worcester East	16	5	9	31.3%	87.5%	21	11	8	52.4%	90.5%	43.2%	89.2%	7/1/16
Worcester West	12	11	0	91.7%	91.7%	22	18	2	81.8%	90.9%	85.3%	91.2%	7/1/16
Central MA Region	**68**	**47**	**18**	**69.1%**	**95.6%**	**68**	**45**	**19**	**66.2%**	**94.1%**	**67.6%**	**94.9%**	
Cambridge - Burlington	2	0	1	0.0%	50.0%	3	2	1	66.7%	100.0%	40.0%	80.0%	12/1/22
Cape Ann	1	1	0	100.0%	100.0%	5	1	3	20.0%	80.0%	33.3%	83.3%	1/1/21
Greater Haverhill	5	0	4	0.0%	80.0%	6	4	2	66.7%	100.0%	36.4%	90.9%	5/1/23
Greater Lowell	20	16	4	80.0%	100.0%	16	12	4	75.0%	100.0%	77.8%	100.0%	7/1/16
Lawrence	10	1	9	10.0%	100.0%	15	9	4	60.0%	86.7%	40.0%	92.0%	6/1/17
Lynn	13	1	6	7.7%	53.8%	4	1	3	25.0%	100.0%	11.8%	64.7%	
Metro North	9	5	1	55.6%	66.7%	5	0	0	0.0%	0.0%	35.7%	42.9%	
Northern Region	**60**	**24**	**25**	**40.0%**	**81.7%**	**54**	**29**	**17**	**53.7%**	**85.2%**	**46.5%**	**83.3%**	
Brockton	8	3	3	37.5%	75.0%	8	2	1	25.0%	37.5%	31.3%	56.3%	5/1/23
Cape Cod	10	5	5	50.0%	100.0%	7	6	1	85.7%	100.0%	64.7%	100.0%	7/1/17
Coastal	7	0	2	0.0%	28.6%	8	1	0	12.5%	12.5%	6.7%	20.0%	
Fall River	9	3	0	33.3%	33.3%	2	0	0	0.0%	0.0%	27.3%	27.3%	
Greater Waltham	7	5	2	71.4%	100.0%	8	6	1	75.0%	87.5%	73.3%	93.3%	4/1/17
New Bedford	9	4	5	44.4%	100.0%	7	6	1	85.7%	100.0%	62.5%	100.0%	6/1/21
Plymouth	10	7	1	70.0%	80.0%	5	2	3	40.0%	100.0%	60.0%	86.7%	11/1/16
Taunton/Attleboro	5	2	2	40.0%	80.0%	7	3	3	42.9%	85.7%	41.7%	83.3%	11/1/16
Southern Region	**65**	**29**	**20**	**44.6%**	**75.4%**	**52**	**26**	**10**	**50.0%**	**69.2%**	**47.0%**	**72.6%**	
Berkshire	7	1	5	14.3%	85.7%	13	6	7	46.2%	100.0%	35.0%	95.0%	8/1/17
Greenfield	12	3	6	25.0%	75.0%	10	7	3	70.0%	100.0%	45.5%	86.4%	7/1/23
Holyoke	7	4	3	57.1%	100.0%	4	4	0	100.0%	100.0%	72.7%	100.0%	1/1/23
Robert Van Wart	17	10	6	58.8%	94.1%	19	4	12	21.1%	84.2%	38.9%	88.9%	4/1/17
Springfield	9	3	4	33.3%	77.8%	7	1	2	14.3%	42.9%	25.0%	62.5%	5/1/17
Western Region	**52**	**21**	**24**	**40.4%**	**86.5%**	**53**	**22**	**24**	**41.5%**	**86.8%**	**41.0%**	**86.7%**	
Grand Total	**275**	**129**	**98**	**46.9%**	**82.5%**	**247**	**127**	**72**	**51.4%**	**80.6%**	**49.0%**	**81.6%**	

Draft for Policy Development Only	Monthly Compliance For Medical Screenings October 2024 – March 2025												
Report Date: 5/28/2025			Boston Region				Harbor Area Office						
Run Date	**Month Screenings Due**	**7 Day Medical Visit Due**	**7 Day Medical Visit Done On Time**	**7 Day Medical Visit Done Late**	**% 7 Day Medical Visits Done On Time**	**Total % Of 7 Day Medical Visits Completed**	**30 Day Medical Visit Due**	**30 Day Medical Visit Done On Time**	**30 Day Medical Visit Done Late**	**% 30 Day Medical Visits Done On Time**	**Total % Of 30 Day Medical Visits Completed**	**Total % Of Monthly Visits Completed On Time**	**Total % Of Medical Visits Completed**
12/15/24	Oct-24	11	5	3	45.5%	72.7%	5	4	0	80.0%	80.0%	56.3%	75.0%
1/15/25	Nov-24	6	1	1	16.7%	33.3%	10	3	4	30.0%	70.0%	25.0%	56.3%
2/15/25	Dec-24	7	3	2	42.9%	71.4%	5	1	1	20.0%	40.0%	33.3%	58.3%
3/15/25	Jan-25	2	1	0	50.0%	50.0%	6	6	0	100.0%	100.0%	87.5%	87.5%
4/15/25	Feb-25	1	0	0	0.0%	0.0%	3	0	1	0.0%	33.3%	0.0%	25.0%
5/15/25	Mar-25	5	2	2	40.0%	80.0%	0	0	0			40.0%	80.0%
		32	**12**	**8**	**37.5%**	**62.5%**	**29**	**14**	**6**	**48.3%**	**69.0%**	**42.6%**	**65.6%**

Figure 2. Medical Visits Trend, 2016 - Present



Medical Social Workers

Since May 2016, the Department has hired 29 medical social workers, one for each area office. These social workers, all LCSWs/LICSWs, support their office by ensuring that all children in placement receive their initial medical screenings and comprehensive visits, preferably within the policy timeframe and with their existing PCP. They have been successful: before they started, 22% of children had medical visits within 6-8 weeks after placement. The March 2024 compliance report showed that 88.2% of children in placement statewide had a medical visit. While statistics fell during the height of the pandemic, they were starting to rebound in February 2022, with 78.9% of children statewide receiving their medical visits. Workforce issues, medical office requirements, and post-pandemic challenges continue to impact compliance statistics, and many pediatric primary care offices are closing across the state, leading to increased wait time for medical visits.

The area office medical social workers perform many other functions related to improving access to health care for youth in foster care. They are considered "champions" for medical, psychiatric, developmental, and dental care for children in Department care and custody and provide daily care coordination, navigating complex barriers related to access to care, forming relationships with medical and behavioral health providers, and serving as a boundary spanner between DCF and the healthcare community, in a shared effort from both to overcome barriers.

The Statewide Medical Social Worker Specialist is the hiring manager for these positions and provides training, supervision, and overall operational navigation and structure to the team of medical social workers. Her responsibilities include:

1. Developing and coordinating ongoing educational and professional training for Medical Social Workers
2. Working in collaboration with the DCF Medical Director and Supervisor of Nurses to develop statewide educational materials on current medical and healthcare trends impacting children involved with the child welfare system
3. Providing daily consultation to medical social workers around complex care coordination barriers
4. Providing statewide care coordination for youth in foster care, providing overflow support and backup coverage for the Department's Medical Social Workers

5. Providing clinical leadership to the Medical Social Workers and HMST, as well as assuming a leadership role on various interdisciplinary committees and task forces
6. Serving as DCF Liaison to MCEs, MassHealth/Member enrollment center, and EHS
7. Participating in statewide projects with MassHealth
8. Working with DCF data analysts to help identify and clarify practice issues that impact data
9. Working with area offices and the ICPC team at DCF to develop appropriate healthcare plans for foster care youth placed out of state. Providers Mandated Reporter training for medical providers and school nurses.
10. Works with providers and provider agencies to support collaboration between DCF and the healthcare organization

Additional responsible of the Statewide Medical Social Worker Specialist include:

1. Statewide Medical Social Worker Specialist works on interagency projects with **MassHealth,** the state Medicaid agency. These projects include solving access to care barriers related to provider billing issues, ensuring former foster care youth are picked up for continued coverage without delay, and addressing any inequities pertaining to Medicaid and access to care barriers for foster care youth, most recently discussions related to a lack of access to pediatric dentistry for Medicaid members (foster youth) living in the Berkshires. Jessica also works on IT projects with MassHealth related to MassHealth IDs for children who are adopted and any insurance barriers related to Special Kids/Special Care youth, a program for DCF youth in foster care with complex care needs. In addition, the ACO/MCO auto enrollments, which began via MassHealth on 4/1/2023, impacted 20% of children in foster, as well as youth who are adopted or have guardianship through DCF. The Statewide Medical social worker met with leadership at MassHealth to discuss the impact on foster care youth, specifically their behavioral health coverage, which could change without notice. She created a behavioral health template letter notifying behavioral providers in the community before the April 1st changes. With the support of the DCF Area Offices, this letter was sent to behavioral health providers to educate them about the pending changes that would impact access to care.

2. Statewide Medical Social Worker Specialist: the Statewide Medical Social Worker provides consultation with DCF area offices related to the **Interstate Compact on the Placement of Children** (ICPC) to increase knowledge and capacity within DCF Offices around establishing healthcare plans for children being placed in foster care out of state. Statewide Medical Social Worker Specialist has led professional development training in this area in addition to daily consultations.

3. Statewide Medical Social Worker Specialists have developed and been leading Adoption and mass health training for Adoption and ADLU teams across the state. This was developed due to an increase in post-adoption calls and requests for support that Statewide Medical Social Worker Specialist was receiving from across the state from adoptive parents needing assistance navigating the MassHealth system. Statewide Medical Social Worker Specialists have also attended foster care support groups in efforts to educate foster and pre-adoptive families about Medicaid and assist with tools to help navigate the Medicaid system.

4. As of January 1, 2023, Section 1002(a) of the **SUPPORT Act** establishes that individuals are eligible in the FFCC (former foster care category) group if they were receiving Medicaid while in foster care under the responsibility of any state. Section 1002(a) of the SUPPORT Act also provides that individuals who meet the eligibility requirements for the FFCC group may be enrolled in that group even if they meet the eligibility requirements for another mandatory eligibility group, so long as the individual is not actually *enrolled* in such group. These required changes are effective for individuals aged 18 on or after January 1, 2023. Statewide Medical Social Worker Specialist leads statewide trainings involving adolescent workers, adolescent outreach workers, and the DCF Area Office Medical Social Workers to educate them on this change. She has created a template letter for former foster care youth moving out of state, which speaks to this eligibility, to assist youth when applying for this coverage out of state.

The Statewide Medical Social Worker Specialist spoke at two national meetings in 2023, addressing the role of relational coordination in improving access to care for children and youth in foster care.

In addition, medical social workers perform the following functions within their office:

- Ensure that all available relevant medical information at the time of removal is documented in the agency database i-FamilyNet.
- Track data and metrics to help increase compliance with agency policy.
- Ensure appropriate coordination of healthcare services from the time youth enter DCF custody.
- Ensure that youth receive appropriate behavioral health screenings and are referred for treatment as needed.
- Establish and maintain effective relationships between the agency and healthcare providers statewide by collaborating, identifying barriers to access, and ensuring that care coordination is established for all youth.
- Identify cases in which further medical consultation should be conducted with the Regional Nurses.
- Collaborate with the Medical Director, the HMST Supervisor, Area Offices, and other specialty units (Regional Nurses, Central Office Medical Social Workers, Substance Abuse Coordinators, Domestic Violence Specialists, and Mental Health Specialists) on individual cases regarding children with complex medical conditions and care coordination.
- Assist DCF staff with identifying youth who need HIV testing, accessing the testing, and documenting the results in the agency database - iFamilyNet.
- Support agency staff with pharmacy issues, including Medication Administration Program (MAP) issues when youth enter group home placements; follow-up on prior authorization for medication; and contact prescribers to inquire if the prior authorization request has been submitted.
- Provide appropriate referrals to community-based healthcare providers; Assist staff with discharge planning.
- Expedite referrals to agency specialists and hospital Child Protection Teams as needed in individual cases.
- Coordinate with agency Area Office staff, Lead Agencies, and substitute caretakers to ensure that staff and care providers have appropriate and relevant healthcare information about youth entering custody.
- Identify healthcare trends, staff training needs, and barriers to accessing healthcare services.
- Evaluate and guide social work practice issues in developing, revising, and implementing healthcare-related policies and practices.
- Utilize the Medicaid Management Information System (MMIS) to help resolve Medicaid and Managed Care Organization barriers to youth accessing healthcare services.
- Facilitate agency training for Area Offices regarding healthcare-related policies or directives.

Safe Sleep

In 2024, the Child Welfare Institute started to offer Safe Sleep training again to staff here at DCF. One of the medical social workers who previously facilitated these trainings has partnered with the Child Welfare Institute staff to lead these trainings. Dr. Costello gave a presentation in May 2024 to the Statewide Manager's Meeting regarding safe sleep practices in response to an increase in deaths of infants due to unsafe sleep practices in the first quarter of 2024. In 2025, plans are underway to develop training for DCF staff on safe sleep practices accessible through MassAchieve.

Addressing Dental and Oral Health Challenges

The medical social work team has responded to many requests from field staff regarding MassHealth dental procedures for children in custody. The main issues of concern have been the need for implants for missing teeth and orthodontics. Often, teeth have been lost because of injury or lack of dental care before entering care. Of note is that MassHealth does not cover implants for any population. We continue to work with Dr. Samantha Jordan, a public health dentist and MassHealth dental director, to develop new criteria to evaluate requests for dental services for children in DCF custody who may have entered placement having experienced health inequities related to lack of previous dental care. Dr. Jordan's focus is on health equity in oral health.

With the help of the MassHealth dental director, we have resolved several issues related to orthodontics (delayed care, provider out-of-area, non-compliance, etc.). We are meeting with Delta Dental and Wonderfund

and have secured an additional $20,000 grant. We are also recruiting dentists to provide pro bono dental work when needed.

Nursing support

There are currently ten nurses on the medical team, which includes the nursing supervisor, five regional nurses, one nurse liaison to Boston Children's Hospital, and three nurses in the Medication Administration Program. The Nursing Supervisor supervises the regional nurses and co-manages the DCF Boston Children's Hospital Nurse Liaison. The MAP nurses report to the MAP director, who reports to the medical director. Due to the expansion of the MAP program into additional programs across the state, we successfully recruited a 3rd RN to join the MAP team.

The Supervisor of Nurses is responsible to:

1. Supervise, support, direct, and evaluate the Regional Nurses.
2. Supervise, support, direct, and evaluate the Psychiatric Social Worker.
3. Work with the Psychiatric Social Worker and Child psychiatrist to plan and manage the Antipsychotic Medication Monitoring Program pilot.
4. Co-supervise the DCF Nurse Liaison at Children's Hospital Boston
5. Develop and revise healthcare-related policies.
6. Plan monthly HMST staff meetings and training by subject matter experts at the meetings.
7. Work with the DCF Child Welfare Institute to plan and implement medically oriented training for staff.
8. Consult on healthcare/medical issues with DCF staff in the Central office, e.g., foster care and adoption units, SIU, legal, policy, and practice.
9. Communicate regularly with the Make a Wish Program Director regarding children in DCF custody who are eligible for "Wishes", send medical documentation, and complete online applications. Well, over 20 children have already received "Wishes" through this process, and several are in the process of getting "Wishes."
10. Manage the process for review of proposed orders to forgo or discontinue life-sustaining medical treatment by obtaining documentation of the recommendations from the treating physician, second opinion physician, and hospital Ethics Committee and collaborating with the Medical Director and make a recommendation to the Commissioner
11. Manage Contracts: a.) Manage contract with Children's Hospital for the DCF Nurse Liaison and the Clinical Consulting service by the Child Protection Team; and b.) Complex Foster Care/Medical Foster Home Program: manage contract issues, review new referrals for placement to determine the medical appropriateness of the children and their care needs, monitor the census of the CFC/Medical Foster homes, and review quarterly reports submitted by the CFC/Medical Foster home agency
12. Function as the DCF lead for clinical and operational management of Special Kids/Special Care (SKSC) Program
13. Manage the Medical Services page of the internal Intranet.
14. Develop and distribute health-related resources for DCF staff in collaboration with the HMST and
15. Represent DCF on the Department of Public Health Medical Review Team, which reviews any individual under age 22 for admission to a nursing home.

Regional Nurses

The Regional Nurses collaborate and partner closely with the integrated clinical practice teams in their Region. The nurse helps implement healthcare-related agency policy and consults DCF staff and DCF foster/adoptive parents and guardians. The nurse assesses the medical needs of children in the Region and recommends policy changes/improvements and broad-based solutions to the Supervisor. The Regional Nurse:

1. Consult on child-specific healthcare issues with individual DCF Regional and Area Office staff and Integrated Clinical Practice
2. Assists staff with interpreting medical record documentation

3. Accesses the Medicaid claims database to create All Services Reports that outline all services provided to a particular child within a period
4. Coordinates healthcare services through communication with healthcare providers and hospitals, including assistance with hospital discharge planning
5. Reviews medical documentation related to payment of foster parents for care of children with special needs (PACT reviews)
6. Assists Area and Regional Office staff with assessing proposed orders to forgo or discontinue life-sustaining medical treatment (LSMT) and accessing physicians to provide second opinions when such orders are proposed
7. Assists with documentation of healthcare information in iFamilyNet and adds healthcare-related documentation to the hardcopy case file
8. Identifies children who are appropriate for the Special Kids/Special Care program and submits the written referrals and medical records to MassHealth for review by the MassHealth pediatrician to determine if a child is medically appropriate for the program
9. Assists the HMST with training for staff and foster parents and helps coordinate training on healthcare issues with the Child Welfare Institute
10. Identifies children appropriate for monthly HMST case conferences and participates in these meetings
11. Develops relationships with local healthcare providers such as physicians, hospitals, school nurses, home care agencies, and mental health providers to help DCF social workers identify a network of providers for accessing necessary services
12. Works with the Supervisor to establish methods to document actual job responsibilities and measure the satisfaction of DCF staff and implement the methods upon approval by the Supervisor
13. Assists social work staff with assessing the appropriateness of HIV testing for individual children
14. Consult with staff on cases before the Regional Fatality Review Boards
15. Participates in HMST meetings held at the DCF Central Office and meetings in the Regional and Area Offices as requested by the Supervisor
16. Participates in DCF Area and Regional Clinical Review Teams and monthly Special Kids/Special Care Case Review Team meetings
17. Participates in weekly or monthly meetings with specific hospital Child Protection Programs in the region
18. Assists with the assessment of foster parent's ability to provide for the healthcare needs of children currently placed in their homes and those who may be placed in their homes in collaboration with the Supervisor and the staffing of the Foster Care Unit at the Central Office; and
19. Assists with the coordination of treatment plans for medically complex children who are transitioning into new foster homes, group homes, and residential placements.

<u>DCF Nurse Liaison (NL) at Boston Children's Hospital</u>

The DCF Nurse Liaison (NL) at Boston Children's Hospital is a member of the DCF HMST and provides essential support and clinical expertise for all DCF staff. She engages in a range of activities that serve to advance the best possible outcomes for medically complex and acutely ill children in DCF custody and facilitate and improve communication among the service providers involved in each child's care. Currently, the NL is a former staff nurse at Boston Children's Hospital who has spent many years in this position and has extensive pediatric nursing experience and expertise with children who need tertiary care. She is in contact with the regional nurses daily and facilitates meetings between BCH medical and social work staff and the DCF teams.

<u>Special Kids, Special Care (SKSC) Program</u>

The Supervisor of Nurses leads the Special Kids, Special Care (SKSC) program, a program for medically complex children in foster care. Massachusetts Medicaid Program (MassHealth) and the Department of Children and Families (DCF) co-sponsor this intensive medical care management program for children in DCF custody and in placement who have complex health care needs through a contract with one of the MassHealth managed health care plans, Wellsense). A pediatrician at MassHealth reviews medical records to determine whether a child is medically appropriate for the program when initially referred and for requests for continued enrollment. When initially enrolled, a child must be in DCF custody and in foster or group care. Suppose a child is subsequently adopted, in guardianship, or returns to biological parent(s). In that case, the child can remain in the program as long as they are medically appropriate and the case is open with DCF. The program serves children from newborn to 22 years of age residing in Massachusetts. Examples of medical conditions of children currently enrolled are uncontrolled diabetes, genetic syndromes, hypoxemic ischemic encephalopathy, liver disease, renal failure, prematurity, spastic quadriparesis, post-infectious encephalopathy, neurological disorders, cystic fibrosis, malignancies, and cerebral palsy. The BMCHP SKSC team includes a Medical Director, five pediatric complex care nurses (two pediatric nurse practitioners and three registered nurses), and administrative staff. As of June 2025, 146 children are enrolled in the program.

Services provided by the program include:

1. A nurse case manager from Wellsense works directly with DCF staff, the substitute caretaker, and the primary care physician to develop a detailed Individualized Healthcare Plan.
2. The Individualized Healthcare Plan is updated quarterly and provided to the DCF social worker, social workers from contracted agencies, and primary care providers.
3. The nurse case manager makes home visits and assesses the child's medical needs, including the need for additional specialty care, home care services, medications, and equipment. The nurse case manager orders and arranges for whatever is necessary.
4. A nurse case manager is on call 24 hours a day, 7 days a week, for DCF staff or substitute caretakers to reach a nurse case manager.
5. The nurse case manager works directly with school nurses and other community and state agencies to coordinate and facilitate services.
6. The nurse case manager works with DCF staff and substitute caretakers to assess the ability of potential respite placements to provide the necessary care and ensure that the respite placement has all essential medical services and equipment.
7. The nurse case manager assesses the child's need for additional specialty care, services, and equipment and arranges for whatever is necessary. The MassHealth prior approval process, which is required for some medical equipment and services, is not required.
8. The primary care physician and nurse case manager work closely with the child's DCF social worker and foster family or group care program to provide management and monitoring of the child's healthcare needs 24 hours a day, 7 days a week.
9. The nurse case manager works collaboratively with school nurses and other community and state agencies to coordinate and facilitate all services and resources that are available and beneficial to the child.
10. The nurse case manager works with the DCF staff and foster parents to assess potential respite placements and ensure that the respite placement has all necessary medical services and equipment.
11. For children transitioning to adoption, guardianship, or biological parents, the nurse case manager:
    - Coordinates and arranges the transition of necessary medical equipment, supplies, and services.
    - Assists DCF in assessing the parents'/guardians' ability to provide the care needed by the child and makes recommendations to DCF staff
    - Can visit a prospective home to determine its appropriateness for meeting the child's medical care needs

Complex Foster Care/Medical Program

The Complex Foster Care/Medical program provides foster homes with skilled and trained caretakers to care for medically complex children. The program offers treatment support to children and youth who require intensive medical care management and coordination.

1. The population includes children and youth from birth through twenty-two years who require intensive medical care and management and are administered through a contract with the Center for Human Development.
2. The program staff includes the director, a social worker, and a case manager for the nurse.
3. The Supervisor of Nurses reviews new referrals to determine whether a child is medically appropriate for this level of care and monitors children in the homes to determine ongoing medical appropriateness and need for transition to other placements.
4. Children and youth in these foster homes are those with technology-dependent, complex, and/or serious medical conditions requiring regular skilled and non-skilled home care, medical advocacy, complex medical management, and services by numerous medical specialists.
5. Children who are medically appropriate for this level of care include those who:
    - Have tracheotomies
    - Require oxygen supplementation
    - Are ventilator dependent for all or part of the day
    - Are diagnosed with cancer and are receiving treatment
    - Have multiple physical disabilities that require 24 hour a day care
    - Are diagnosed with serious birth defects that impair their functioning and require skilled care
    - Have serious medical conditions resulting from prematurity; or
    - Require intravenous or tube feedings and have complex or unstable medical conditions.

Access to Medical History Information through Claims Data

The Supervisor of Nurses collaborated with the MassHealth Privacy Office at the Executive Office of Health and Human Services (EOHHS) to establish access to the EOHHS Data Warehouse through the Cognos reporting system.

1. The Supervisor of Nurses, Regional Nurses, Medical Social Workers, Psychiatric Social Workers, and Consultant Psychiatric Nurse Practitioners have access to MassHealth claims data electronically and create "All Services Reports," which are reports of claims for all services within a specified time period for children in DCF custody.

2. The reports provide DCF social work staff with up-to-date information about medical, dental, behavioral health, pharmacy, home health, medical equipment, and enrollment in MassHealth managed care plans, which is crucial for coordinating and managing a child's healthcare services and medical conditions.

3. The reports are particularly valuable when a home removal is done and there is a lack of medical information regarding the child(ren).

4. The reports include information about coverage through the MassHealth Managed Care Plan (about 20% of foster children), allowing care coordination with the Managed Care Plan, its providers, and the Massachusetts Behavioral Health Partnership

5. The claims detailed in the reports include medical history information regarding a child's medical conditions, medications, primary and specialty medical care providers, hospitalizations, therapies, home care services, procedures, medical equipment vendors, pharmacies, and behavioral health services.

How Medical Information Will Be Updated and Appropriately Shared

A DCF data analyst worked closely with Data Warehouse Informatics at EOHHS (Executive Office of Health and Human Services) to set up a data transfer process for MassHealth (Massachusetts Medicaid) medical information. The Department now receives automated monthly medical data transfers for children in DCF care or custody. These data include the following: medical, dental, and behavioral health claims (including diagnoses and procedures), provider information, drug information, Medicaid plans, and eligibility for federal and state programs. Going back to October 2015, patient medical history is included for all children currently in care or custody. The EOHHS data warehouse staff remain available for questions, custom data runs, or data-sharing enhancements. This process has also made them more familiar with DCF information stored by EOHHS, which may be helpful for further collaboration.

Data from MassHealth is stored securely in DCF's Oracle 12c database and can be linked to the DCF SACWIS and i-FamilyNet systems. This allows us to query medical and child welfare data simultaneously. It also extends query capability to DCF Information Technology (IT) and other DCF analysts. Some current projects include:

- Psychotropic drug reports sorted by drug class, child's age, race/ethnicity, and number of medications (polypharmacy)
- Reports on antipsychotic medications, and new antipsychotic orders
- Review of metabolic monitoring claims (required lab work) for youth on antipsychotic medications.
- Reports on foster children with diabetes diagnoses and insulin use; these are distributed to the appropriate regional nurses for follow-up
- Reports on fractures and other injuries indicative of abuse, to be reconciled with i-FamilyNet data

Data is available both on the population level, to examine overall trends, and on an individual level. This allows DCF to identify children whose medical history requires further review by medical professionals.
Per the recommendations of the FFPSA, the following information can be queried if desired:

- Diagnoses and procedures cross-referenced to placement location, service types, and other internal DCF information
- Children with unusual treatment plans
- Children with marked instability in medical providers
- Providers or institutions with habitual divergence from accepted medical guidelines

DCF also tracks medical information in its own i-FamilyNet SACWIS, including records of medical visits, procedures, medical conditions, allergies, drugs and medical equipment, and other information as recorded internally and through contact with medical providers.

- DCF has established a process to import all psychotropic Medicaid claims into i-FamilyNet for youth in state custody to ensure psychotropic medications are up to date and also provide a record of what the youth has taken in the past.
- DCF does not currently import data directly from provider EHRs (electronic health records) but it is anticipated that the DCF/EOHHS IT team will be able to do so when future opportunities to interface are available. Please see above about pilot to integrate the UMASS EPIC medical record system and i-i-FamilyNet.

Plans for the FFY 2026 include:

- Continuing to assess psychotropic drug use trends quarterly by drug class, age, race/ethnicity, and number of medications.
- Extending reports for the regional nurses to other diagnoses of interest, e.g., asthma
- Tracking compliance with well-child visit schedules
- Streamlining medical report delivery in collaboration with DCF IT

In addition, see above Section II for Access to Medical History Information through Claims Data

III. Steps to Ensure Continuity of Health Care Services, Which May Include Establishing a Medical Home for Every Child

The Department is committed to ensuring the continuity of health care services. All efforts are made to schedule the initial screening and comprehensive visits in the medical home that was established prior to coming into foster care. When this is impossible, medical visits are scheduled with a healthcare provider close to the foster home or group care facility. Many of these visits occurred virtually at the outset of the pandemic, but most are now in person.

As noted above, if the Department does not know previous medical providers, multiple medical support staff in the agency can pull Cognos Medicaid reports to provide this information for children receiving MassHealth services.

Since the Medical Social Workers began in May 2016, they have developed close relationships with their area's medical practices, community health centers, and hospitals. Their ongoing communication and collaboration with the medical community have allowed them to schedule children for visits sooner than in the past.

There is a foster care clinic at the University of Massachusetts Medical Center, FaCES (Foster Children Evaluation Service), associated with the Pediatric Department of the University of Massachusetts Medical School. The clinic subscribes to an "evaluation model" where they see children soon after placement, obtain all their medical records, update their medications and immunizations, make referrals to subspecialists as necessary, compile all relevant information, and then send these children on to a medical home for ongoing primary care and health care coordination. Medical social workers work closely with FaCES to ensure that children get their initial screening and comprehensive visits promptly

IV. Oversight of Prescription Medications

Youth in state custody has two psychotropic oversight processes to ensure the appropriate prescribing of psychotropic medications. The first is an oversight program through MassHealth for all youth enrolled in the state Medicaid program called Pediatric Behavioral Health Medication Initiative (PBHMI), and the second is specifically for youth in DCF custody who are prescribed antipsychotic medications called the Rogers Process.

Massachusetts implemented a prior authorization psychotropic oversight program, PBHMI, in 2014 through the MassHealth Pharmacy Program with collaboration from the Department of Children and Families (DCF) and the Department of Mental Health (DMH). Prior authorizations (PAs) are required for high-risk psychotropic medication regimens for all youth on MassHealth, including youth in state custody. Medication regimens that include polypharmacy (four or more psychotropic medications), age restrictions (all psychotropic medications for youth less than 3yo, all psychotropic medications except stimulants and alpha agonists for youth less than 6yo), and psychotropic class duplication (two or more antidepressants, two or more antipsychotics, two or more benzodiazepines, three or more mood stabilizers) require PA form to be filled out by the prescriber and then approved by the MassHealth Pharmacy Drug Utilization Review program before the medication being filled at the pharmacy. The highest-risk medication regimens receive limited approval and are referred to an interagency review team (Therapeutic Class Management Team) that includes two board-certified child and adolescent psychiatrists, clinical social workers, and three or more clinical pharmacists. Information on the highest risk cases is discussed in a weekly interagency meeting, which includes representation from DMH, DCF, Massachusetts Behavioral Health Partnership (MBHP), and MassHealth. Outcomes from the TCM discussions can include scheduling a doctor-to-doctor phone call with the prescriber and one of the child psychiatrists, referral for care coordination through MBHP, or approval of the regime by extending out the PA.

The second oversight process for youth in state custody, the Rogers Process, provides court-ordered consent for antipsychotic medication. DCF defers consent for antipsychotic medication to the court for approval. As part of the court process for review, the judge appointed a Guardian Ad Litem (GAL) to review the request for

antipsychotic medication.

In 2021, DCF launched a pilot program to provide additional medical oversight to help inform the court's recommendation when children are started on antipsychotic medication called the **Antipsychotic Monitoring Program** (AMP). This pilot initially started in the Central Region and expanded statewide in 2024. The AMP program provides a medical review of all new requests for antipsychotic medication to help inform the court about appropriate prescribing for youth in state custody. As part of this review, DCF has created two new positions, the psychiatric social worker and the consultant psychiatric nurse practitioner, to help coordinate and communicate around these reviews. The role of the Psychiatric Social Worker is to collect information necessary to determine the appropriateness of the medication from DCF social workers, collaterals, and clinical information about the rationale for the medication and relevant treatment alternatives. The Psychiatric Social Worker collaborates with the DCF Consultant Psychiatric Nurse Practitioner and DCF Child and Adolescent Psychiatrist. The Consultant Psych NP helps to support the initial AMP reviews and communication with the medical system. The DCF Child and Adolescent Psychiatrist (CAP) reviews all requests for antipsychotic medication to assess for appropriateness. If there are concerns about the high-risk prescriber, the DCF CAP will have a professional conversation with the prescriber to outline concerns and treatment recommendations.

The AMP program also has the capacity for tracking and data collection on cases that have been reviewed for quality assurance. This year, the AMP program has piloted a review of antipsychotic monitoring by looking at lab work claims that are required for antipsychotic medications. We hope to make this an annual process.

Overall, the AMP program has provided an added safety net for our youth who have started on antipsychotic medications. The program has created a structured process to review the appropriateness of the medication request, including flagging drug-drug interactions, dose ranges, and monitoring requirements.

DCF has developed a process to look at all psychotropic medical claims for children in state custody each quarter. The consultant child psychiatrist reviews this data to look at any trends concerning prescribing practices.

The Health and Medical Services team at DCF also has a process for reviewing requests for psychotropic consent when prescribers in the community would like to start or change medications. The ongoing worker can access their regional nurse to review medication requests utilizing a standard "Dear Dr Letter" form. Regional Nurses provide an initial review of psychotropic medication consent forms. If there are any questions or concerns with a medication request, Regional Nurses send the Dear Dr. Letter to the Psychiatric Consultant Nurse Practitioner for review and/or Consultant CAP at Central Office.

Plans for FFY 2026 include:

- Further investigation of psychotropic drug use, including medication adherence and drug regimens (including polypharmacy)
- Extending reports for the regional nurses to other diagnoses of interest, e.g., asthma
- Tracking compliance with well-child visit schedules
- Streamlining medical report delivery in collaboration with DCF IT
- Documenting consent for psychotropic medications in i-FamilyNet. Foster parents are the first consenters, and the ongoing social worker will review at monthly meetings with foster parents and add their consent. THE HMST is always available to field questions or concerns from the social work teams.

In addition, see above Section II for *Access to Medical History Information through Claims Data*

V. Steps to Ensure Continuity of Health Care Services, Which May Include Establishing a Medical Home for Every Child

The Department is committed to ensuring the continuity of health care services. All efforts are made to schedule the initial screening and comprehensive visits in the medical home established before coming into

foster care. When this is impossible, medical visits are scheduled with a healthcare provider close to the foster home or group care facility.

As noted above, if the Department does not know previous medical providers, the Data Analyst can search Medicaid claim data to obtain this information for children receiving MassHealth services.

Since the Medical Social Workers began in May 2016, they have developed close relationships with their area's medical practices, community health centers, and hospitals. These workers' ongoing communication and collaboration with the medical community have allowed them to schedule children for visits sooner than in the past.

Medication Administration Program

The Department of Public Health (DPH) serves as the lead agency for the statewide Medication Administration Program (MAP), which is overseen by the Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Children and Families (DCF), and the Massachusetts Rehabilitation Commission (MRC). The overall goal of MAP is to increase the safety and security of medication administration for individuals living in DDS, DMH, DCF, and MRC licensed, funded, or operated community residential programs that are the primary residences and/or participating day programs and short-term respite programs. MAP makes it possible for unlicensed direct care staff to become certified in safe and secure medication administration within MAP policy and procedures guidelines. MAP is implemented through uniform, statewide standards that undergo continuous evaluation and improvement. MAP Director Eric Volz-Benoit is responsible for overseeing and implementing the Medication Administration Program for DCF with the assistance of DCF MAP Coordinators. In addition to MAP oversight, the MAP Director and Coordinator provide technical assistance and support to more than 160 MAP-registered congregate care programs and more than 150 non-MAP registered sites. Over the past year, the DCF MAP team has worked with DPH and DCF congregate care program vendors to convert more than 45 Emergency and Intensive Emergency Residence vendor programs to MAP compliance, allowing safe medication administration within programs that were not previously using MAP.

DCF MAP Director and MAP Coordinator duties include:

- MAP oversight for the Department of Children and Families (DCF)
- Provided technical assistance to DCF about MAP, as well as supported DCF vendor programs with MAP compliance.
- Monitor the Certification/Re-certification testing process through the contracted testing vendor.
- Collaborate with and oversee the MAP testing vendor contract, reconcile billing, and address problems/issues with the testing vendor, verify tests, create and revise testing questions, ADA requests, and waivers for testing.
- Oversee the Medication Occurrence Reporting (MOR) system, identify trends in Medication Occurrences, and address medication occurrences with vendor programs.
- Oversee the informal hearing process for MAP Certification disciplinary actions, including suspension and revocation.
- Meet with DCF Network Specialists and Directors to support their role with vendor programs and provide education and assistance in MAP, medication administration, and medically related issues for youth in congregate care sites.
- Attend weekly MAP Administrator meetings with DDS, MRC, and DMH and bi-weekly meetings with DPH to discuss oversight, changes to MAP Policy, and identify MAP trends of concern.
- Provide technical assistance in maintaining overall vendor program MAP compliance within vendor programs.

- Conduct annual vendor program site audits and develop a Corrective Action Plan (CAP) for any medication administration-related or MAP Policy deficiencies to ensure compliance of vendor programs to MAP policy· Provide technical assistance to vendor programs around medication administration.
- Meet with vendor program nurses, Nurse Monitors, and executive staff to support vendor programs with MAP compliance. Create and disseminate quarterly MAP Nurse Monitor Newsletter and host quarterly Nurse MAP Monitor meetings to discuss trends in MAP, upcoming changes to MAP, areas of improvement for MAP compliance, and provide a forum for RN MAP Monitors to discuss difficulties within programs with their MAP peers.
- Collaborate with DCF Regional Nurses, Medical Social Workers, and Departmental Social Workers to support their role in working with vendor programs in relation to MAP compliant medical care and medication administration
- Participate in reviewing and updating MAP Policy in conjunction with DPH, DDS, MRC, and DMH
- Review allegations of vendor program abuse/neglect (51A's), and provide recommendations to Special Investigative Unit (SIU) investigations
- Provide medication administration technical assistance to Emergency Residence/Intensive Emergency Residence Programs
- Attend DCF team meetings to address ~~overcoming~~ issues with placing youth that may have a medication regimen that would be contradictory to MAP and assist with problem solving.
- Attends the monthly HMST meetings to update regional nurses on MAP
- Develop and conduct trainings to support vendor programs in policy updates, periodic MAP Advisories, and new policy roll out
- Attend and conduct vendor program meetings to aid in interpreting MAP Policy, as well as provide support to vendor programs, assistance with MAP waiver requests to DPH
- Provide technical assistance to other non-MAP vendor programs, community health centers, Health Care Providers (HCP), mental health professionals, DCF staff, and community resource providers
- Attend the Commissioner Miller's monthly provider meeting to provide MAP related updates and support.
- Meet as needed with the provider Trade Union to clarify MAP Policy and provide support.

In February 2022, DPH, with the support of DDS, MRC, DMH, and DCF, commissioned the Eastern Research Group (ERG) to evaluate issues impacting medication administration by unlicensed but MAP Certified Staff with the intent to recommend actions or changes to MAP Policy that may alleviate issues confronting MAP. Over six months, ERG surveyed other states' medication administration forms, as well as Massachusetts MAP Certified Staff and vendor programs. Since the release of the ERG report, the MAP Policy has been revised several times to reflect the recommended changes and updates suggested by the ERG report and subsequent work groups. Due to the number of MAP Policy changes, the DCF MAP team has worked collaboratively with DPH, DDS, DMH, and MRC to revise MAP Curriculum and MAP Testing. The ERG Report showcased 30 recommendations that fall into six categories that may address MAP issues and how to modernize MAP to enable more staff to become MAP Certified and maintain the safety that MAP strives to keep in place for vendor programs. The six ERG recommendation categories recommendations are:

1. Establish an Interagency MAP-related Data Center
2. Allow and Promote Use of Electronic Medication Administration Record (eMAR) System
3. Medication Administration
4. Over-the-Counter (OTC) Exempt Products Tier
5. MAP Certification Training and Testing
6. MAP Staffing and MAP as a Career-Building Entry-Level Position

After the release of the ERG report, DPH, DDS, MRC, DMH, and DCF conducted many meetings to establish a plan for determining which recommendations to implement or adapt to implement. A MAP Modernization Committee was implemented, consisting of DPH, DMH, DDS, MRC, and DCF staff, as well as community

congregate care providers and the trades, in order to consider the recommendations and determine which recommendations would be adopted, adapted, or rejected. The MAP Modernization Committee was split into six sub-committees to oversee the evaluation of each suggested category in the ERG Report. Each sub-committee meets every two weeks to discuss the pros and cons of each recommendation, how to implement the recommendation, or how to modify the recommendation to maintain MAP safety. Some adopted recommendations are currently being written into policy change advisories, while other adopted and adapted recommendations require system change and a more extensive implementation process. New policy change advisories will be coordinated between DPH and DDS, DMH, DCF, and MRC for rollout over the next 6 months.

DCF MAP Director is currently working with DPH to complete the process of converting the DCF Emergency Residence and Intensive Emergency Residence (ER/IER) Programs into MAP compliance. The DCF MAP team continues to work with congregate care provider vendors to complete the process of MAP conversion. Several trainings have been held with congregate care provider vendors to support them through MAP conversion to help walk them through the implementation process, create as-needed waivers, and develop a path for vendor programs to obtain MAP MSCR registrations and begin to administer medications under MAP Policy. Several training sessions have also been conducted with DCF staff to assist them with the process of MAP conversion, and the MAP team continues to work collaboratively with DCF staff and congregate care vendors to provide support through this process.

With the addition of the newly MAP-converted ER/IER Programs, the DCF MAP Team provides medication/medical technical assistance to all vendor programs. It now provides yearly MAP audits to more than 160 Community Treatment Residence (CTR)/Specialty Treatment Residence (STR)/Intensive Treatment Residence (ITR) programs, 4 Commercial Sexual Exploitation of Children (CSEC) programs, 1 Medically Complex Residence program, and more than 35 Emergency Residence (ER)/Intensive Emergency Residence (IER) programs, for a total of 157 MAP programs.

Breakdown of all DCF Congregate Care Programs that the MAP Team provides support to:

- Residential School Programs (Res Ed): 104 (non-MAP)
- Community Treatment Residence (CTR)/Specialty Treatment Residence (STR)/Intensive Treatment Residence (ITR): 106 (MAP)
- Emergency Residence (ER)/Intensive Emergency Residence (IER): 44 ~~(soon to be MAP)~~
- Commercial Sexual Exploitation of Children (CSEC) Programs: 4 (MAP)
- Medically Complex/Medically Behavioral Complex: 1 (MAP)
- Young Parent Living Program: 15 (non-MAP)
- Youth and Young Adult Supported Living Program: 22 (non-MAP)
- Youth and Young Adult Group Residence: 12 (non-MAP)

VI. How DCF Actively Consults with and Involves Physicians or Other Appropriate Medical and Non-Medical Professionals in Assessing the Health and Well-being of Children in Foster Care and in Determining Appropriate Medical Treatment for Children

Training

The Medical Director, consulting child psychiatrist, and medical team train new DCF social workers and newly promoted staff (supervisors, area program managers) on medical protocols, medications, when to consult, and most recently, on all COVID issues. Dr. Costello, April 2025, presented to the new supervisor group about the HMST and their availability to support the teams.

Children's Hospital in Boston and UMass FaCES (Foster Children Evaluation Services) Clinic train DCF Social Workers and periodically offer additional workshops/in-service training opportunities on selected medical topics. In addition, Children's Hospital staff provides training for all DCF investigators on the

assessment of non-accidental trauma.

Protocol for Life Sustaining Medical Treatment

For proposed orders to forgo or discontinue life-sustaining medical treatment, DCF has established processes for accessing medical recommendations from providers in addition to the treating provider and from hospital Ethics Committees. Once these professional opinions have been obtained, the request is reviewed by the medical director and supervisor of nurses, who recommend the proposed recommendations to the commissioner, deputy commissioners, and general counsel. If approved, the Department seeks a judicial decision. The Regional Nurses facilitate a review of each order annually with the child's current medical provider to determine whether the order is still medically justified. The supervisor of Nurses maintains records of all orders and annual reviews.

Collaboration with Child Protection Teams

The medical team works closely with CPTs in hospitals statewide to collaborate regarding a range of healthcare and psychosocial issues for children who have experienced suspected physical or sexual abuse. Physicians and the DCF Nurse Liaisons from Children's Hospital CPT train new social workers and investigators on the assessment of non-accidental trauma. Regular meetings between HSMT and CPT staff statewide are held regularly.

VII. Procedures and protocols to ensure that children in foster care placements are not inappropriately diagnosed with mental illness

As noted above, DCF has a child psychiatrist who consults whenever needed to ensure that youth receive the correct diagnoses and treatment. DCF also supports five Regional Mental Health Specialists across the state. The Regional Mental Health Specialists are licensed social workers with expertise in the mental health system and support Area Offices around complex mental health cases. This role also provides support to youth who are in a psychiatric hospital level of care to ensure appropriate and timely discharge planning, supporting youth to transition back to their foster homes when possible and avoid unneeded extended hospital stays. Regional Mental Health Specialists work closely with both DCF Child Psychiatrists and DMH Area Child & Adolescent Psychiatrists to ensure youth receive appropriate mental health support to support appropriate placements.

Dr Morgan, consulting child and adolescent psychiatrist to DCF, works 3 days/week with DCF and provides consultation regarding cases. She has reserved hours every week to be available to teams around questions and concerns regarding mental health issues, medications, etc. She is mindful of the degree to which trauma can create symptomatology suggestive of mental illness and helps teams and providers understand this in the context of children and youth in foster care.

Youth in DCF custody also have access to the Massachusetts Child and Adolescent Psychiatry Access Program (MCPAP). MCPAP provides access to behavioral and mental health services by making child psychiatric consultation available to primary care doctors across the state. This allows for youth in DCF custody to have appropriate diagnosis and treatment planning developed through their primary care doctor.

VIII. Health Care Needs of Youth Aging out of Care

Planning for discharge and transition from placement and case closing can begin at many different points. Still, the Department must, beginning 90 calendar days before discharge and case closing, provide a transition planning process in collaboration with the youth/young adult based on assessing their readiness for living interdependently in the community, age, and follow-up support. The discharge and transition planning process must include a discussion of the youth/young adult's education, employment or work skills development, housing, and health insurance, including the importance of a medical health care proxy, local opportunities for mentoring, and other specific support services. The plan should be reflected in the Service Plan and/or dictation

and reported in any Permanency Hearing Report filed with a court after the youth/young adult turns 17 years and nine months old. Any outstanding life skills needs are prioritized and addressed before discharge from placement and case closing. The Department must also provide written notice to the youth/young adult at least 30 calendar days before the anticipated discharge date from placement and case closing (which may occur later). Both steps should be planned.

- For the youth who intend to leave Department care or custody on their 18th birthday, the discharge and transition planning must begin 90 calendar days before discharge and the closing of the case. The written notice of discharge from placement and case closing should be sent within 90 calendar days and at least 30 calendar days before their 18th birthday. The notice must contain notice of the right of the youth to challenge the discharge from placement and the closing of their case through the fair hearing process.

- For the young adults who have continued sustained connections with the Department beyond age 18, the discharge and transition planning are completed 90 days before the closing date. The dates for discharge from placement and case closing should be reflected in the youth readiness assessment tool if it is being utilized and the current service plan. Written notice of the discharge from placement and/or case closing is sent at least 30 calendar days before the date of the discharge from placement or case closing accordingly.

- Please see the section above regarding the SUPPORT Act for current initiatives related to health care for youths who are out of care again.

APPENDIX A

Eileen Costello, MD, was appointed the second Medical Director of the Massachusetts Department of Children and Families in April 2023. She joined the Department full-time on May 1, 2023, from Boston Medical Center (BMC), where she was the Medical Director of the Pediatric Primary Care Clinic, the Chief of Ambulatory Pediatrics at Boston University School of Medicine, and Clinical Professor of Pediatrics

Dr. Costello's 35-year career has been dedicated to providing top-flight medical care to children across Boston. Some of our workers with ties to the Boston Region may remember her from her years as a staff physician at Dorchester House and the Southern Jamaica Plain Health Center in addition to her tenure at BMC.

Dr. Costello's specialties and interests align with the increased acuities we are seeing among children, including autism spectrum disorder, neuro-developmental disorders, and psychiatric illness. At BMC, her responsibilities included serving as medical director of the Supporting Our Families through Addiction and Recovery (SOFAR) clinic and the director of the family task force at the Grayken Center for Addiction.

In Dr. Costello, we are gaining a compassionate colleague, a creative problem-solver, and community-minded, as evidenced by more than 15 years as the consultant pediatrician to the Boston Baseball Camp and the Franklin Park Coalition Youth Programs. Dr. Costello will be based at the Central Office and working across all five regions.

Linda D. Sagor, MD, MPH, was appointed the first Medical Director of the Massachusetts Department of Children and Families in 2016. She is a Professor of Pediatrics at the University of Massachusetts Chan Medical School, where she served as a primary care pediatrician and Division Director of General Pediatrics for many years. In 2003, she founded the FaCES (Foster Children Evaluation Services) Clinic at UMass and served as director until 2015. She was a member of the Executive Board of the American Academy of Pediatrics Council on Foster Care Adoption and Kinship Care and is currently chair of the Massachusetts chapter of the AAP Foster Care Committee. Among the awards she has received are the American Academy of Pediatrics Thomas Tonniges Lifetime Achievement Award for Advocacy of Vulnerable Children, the Manny Carballo Governor's Award for Excellence in Public Service along with her DCF team of 29 medical social workers, the Massachusetts Medical Society Henry Ingersoll Bowditch Award for Excellence in Public Health, the University of Massachusetts President's Public Service Award, and the Leonard Tow Humanism in Medicine Award.

Wynne Morgan, MD, is an Assistant Professor of Psychiatry at UMass Chan Medical School and Co-Program Director for the FaCES Safe and Sound clinic at UMass Children's Medical Center, an integrated behavioral health clinic for youth entering foster care. Dr. Morgan is also the Consultant Child Psychiatrist for the Department of Children and Families Office of the Medical Director and helps lead psychotropic oversight efforts for youth in foster care across Massachusetts.

Since joining the DCF Heath and Medical Services Team in 2016, Dr. Morgan has worked to ensure the appropriate prescribing of psychotropic medications for youth in state custody. She works closely with MassHealth Pediatric Behavioral Health Medication Initiative to review DCF youth who are flagged for high-risk prescribing. In 2021, Dr. Morgan launched a pilot program targeting the

appropriate use of antipsychotic medication for youth in state custody called the Antipsychotic Medication Monitoring Program, which has expanded to three of the five DCF regions.
At a national level, Dr. Morgan has been a member of the American Academy of Child and Adolescent Psychiatry's Adoption and Foster Care Committee since 2012 and has been Co-Chair since 2018. She is also the current committee liaison to the American Academy of Pediatrics COFACK Executive Committee. In these roles, Dr. Morgan has led efforts around psychotropic oversight for youth in foster care and efforts to standardize how children are taken off medication through deprescribing.

Dr. Morgan has published and presented on numerous topics related to the mental health care needs of youth in foster care. In 2018, she received the inaugural Marilyn Benoit Child Maltreatment Mentorship Award from AACAP for her work within the child welfare system.

APPENDIX B – Additional Information About Programs

Regarding psychotropic and antipsychotic medications:
DCF collaborated with the MassHealth Pediatric Behavioral Medication Initiative (PBHMI) Quality Assurance Committee to review MassHealth's current safety parameters for high-dose psychotropic medications in pediatric populations in January 2025. This interagency Committee includes DCF, MassHealth, DMH, and the MassHealth Clinical Pharmacy team, which comprises Child and Adolescent Psychiatry and Clinical Pharmacy experts. The Committee reviewed the current mechanisms in place at MassHealth for catching psychotropic medications that are at high doses and also reviewed data showing the prevalence of the use of high-dose medications in two of the highest-risk classes, alpha-agonists and antipsychotic drugs. The Committee determined that PBHMI MassHealth had sufficient oversight and safety parameters in place to detect high-dose medications that posed a safety risk, and additional oversight measures were not necessary at this time. No changes to the current definitions of high-risk prescribing in pediatric populations were recommended, as defined by PBHMI MassHealth.

Family Care Plan (also federally known as Plan of Safe Care):
Over the last two years (2023-2025), DCF has worked closely with the Massachusetts Department of Public Health Bureau of Family Health and Nutrition (of which the Bureau of Substance Abuse Services is a part) and the National Center on Substance Use and Child Welfare on an In-Depth Technical Assistance (ISTA) project regarding new legislation in Massachusetts. The new legislation removes the mandatory reporting of infants with prenatal substance exposure if their mothers are stable in recovery. Suppose mothers are on medications for opioid use disorder that a medical provider prescribes. In that case, this no longer requires a mandated report unless there are concerns about the capacity to care for a newborn.

Plans of Safe Care, now called Family Care Plans, are critical of this work. We have developed a draft FCP and a portal through which birthing hospitals and facilities will report the birth of a substance-exposed newborn, as required by CAPTA, and offer the opportunity to file a mandated report if there are concerns about safe discharge. The Family Care Plan is a document that details referrals to a coordinating agency and community-based support for mother/infant dyads. DCF and DPH are starting a learning collaborative with providers and subject matter experts to learn best practices and educate the workforce about the new legislation, our regulations, and guidance. We will pilot the program in two birthing hospitals, one academic medical center, and one community hospital to best understand any obstacles to implementation.

ISA with UMASS medical center regarding Autism evaluations for children in care:
DCF signed an interagency service agreement with the UMASS FaCES clinic to expedite autism evaluations for children 0-12 in our custody. Autism is a common diagnosis in the general public and seems to be over-represented in children in our care. Wait lists for autism evaluations in Massachusetts can be up to 18 months long.

The UMass FaCES clinic now employs a 0.5FTE developmental psychologist to administer autism evaluations (using validated instruments such as the CARS-2, ADOS, or RITA-T) at the UMass Memorial Children's Medical Center for children in DCF custody with a concern for autism, between the ages of 0 and 12 years old. This will be done in collaboration with the Developmental and Behavioral Pediatrics division and the FaCES Clinic and will be supported by the Shriver Center. These pediatric specialists have extensive experience with autism, child trauma, and family support for both. Children are to be referred for the evaluation. Results will be made available to the child's DCF team and pediatrician, and the DCF and pediatric providers will undertake further management of their care.

More than 30 children have been evaluated in the first months of this pilot, and we recently signed the 2026 ISA to continue this service. Of note, although all of the referrals for this evaluation were deemed appropriate, many of the children were manifesting symptoms of trauma that overlap with those of Autism Spectrum Disorders. These diagnostic evaluations must be done with specialists who understand the impact of trauma many of the children in DCF custody have experienced so appropriate services can be put in place.

Scope of services:
1: To provide autism diagnostic evaluation for youth in child welfare custody.
Objectives:

1. Provide an accurate evaluation of children with autism symptoms in DCF custody performed by a developmental psychologist.
2. Address unmet developmental diagnostic needs of children in care with prompt and accurate diagnosis which would also provide documentation needed to access autism specific services.
3. To identify neurodevelopmental diagnoses in the context of child trauma in DCF involved youth.

2: Provide autism specific information to child welfare and families caring for youth.
Objectives:

1. Educate DCF worker, foster/kin parents on what to expect from autism services and how to best access services.
2. Connect caregivers to resources in the community that can help provide autism support. Caregivers need to know that they have support and that they are not the only ones responsible for the development and nurturing of the child.
3. Provide emotional as well as educational supports to DCF and foster/kin parents, practically promoting their parenting success with children with challenging behaviors.

3: Promote placement stability and reunification success.
Objectives:

1. Promote understanding of behaviors by foster/kin parents and youth which reduces sense that autism cannot be addressed and overcome.
2. If reunification is an option, improve likelihood of reunification success by supporting reunification efforts with the resources needed to address child needs in home of origin.

DCF will be responsible for ensuring the completion of following activities, roles, and responsibilities:
• Referrals will come from DCF Central region. Referrals will be based on mutually agreed upon criteria. Standardized referral form will be created based on mutually agreed criteria. Local pediatricians will also be made aware of this service and can refer if needed and child in DCF custody.

Terms of performance
DCF and FaCES will meet twice per year to provide updates on services. DCF and FaCES will schedule mutually agreed upon time for biannual status meetings. FaCES will provide a quarterly written report of numbers to DCF of how many youths are being referred and number provided autism evaluations.

3. Identify schedule of performance or completion dates or other benchmarks for performance, or as amended.

UMMS will provide a lot of consumers served to DCF Central office, and information on what resources are provided to youth and families. DCF and FaCES will schedule mutually agreed upon time for biannual status meetings. FaCES will provide a quarterly written report of numbers to DCF of how many youths are being referred and number provided autism evaluations.