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 Jessica Coolidge, 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 May 2024.

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. **Each area office has one person who is accountable for ensuring that all relevant medical information** (chronic diagnoses, recent acute diagnoses, medications, allergies) is obtained, communicated to social worker and foster/kinship parent within 24 hours of child entering placement, and documented in iFamilyNet. This person would collaborate with DCF social workers and management team to ensure adherence to the medical examination policy, especially with respect to timing of medical exams and documentation of exam information. The concept of a "medical team" made up of a nurse and medical social worker would ensure that necessary clinical and administrative functions are completed. The ideal number of medical teams would be determined by number of cases for which they would be accountable. Nurses in this position provide consultation on medical issues for individual cases and is an active liaison to medical providers in his/her area as well as provide ongoing education and trainings to the field on healthcare trends/topics. Ongoing social workers would continue to be responsible for strength-based case practice by engaging families and obtaining medical information from the beginning of their work with families. Substitute caretakers would continue to be responsible for scheduling and attending all medical

appointments with their foster child*:* Starting in May 2016, each of the 29 area offices has one medical social worker (see below). They are recognized among their colleagues and by foster parents as the "champions" for excellent medical and psychiatric care for all children in custody.

3. The current policy (with rigid guidelines for 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 receive the care he/she needs within the *appropriate* time frame (e.g., though some children would require screening with 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) as well as continued work with community medical providers to ensure timely access. The policy has not changed at this time. The area office social workers, with the help of the medical 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 consult with the Medical Director and their Regional Nurse at all times.

4. 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.
5. **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 documents 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.

6. There should be **consistency in data collection** and practice among all DCF Regions, starting with the gathering of 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 useful 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 date, medical conditions, allergies, medications, and immunizations in iFamilyNet. This information is now being made available as appropriate to foster parents on their portal, Foster MA Connect.

7. Additional **education and training** about 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

Currently, medical director Dr. Costello and consultant Child and Adolescent Psychiatrist Dr. Wynne Morgan provide regular trainings to teams. Recent trainings include Safe Sleep Practices, Outcomes for Children of Parents with Substance Use Disorders, Understanding Psychotropic Medications, 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 in January 2016. In addition, Dr. Wynne Morgan was hired as consulting child psychiatrist in spring 2016. (biosketch for Drs. Sagor and Morgan available in Appendix). Dr. Sagor stepped down from this position on April 30, 2023, and Dr. Eileen Costello, formerly chief of ambulatory pediatrics at Boston Medical Center, Clinical Professor of Pediatrics at Chobanian and Avidisian School of Medicine at Boston University was appointed as medical director on May 1. 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.

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

Please see update on progress below.

II. How health needs 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:

a. 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
b. A Child-Specific report is issued weekly and provides a listing of each child who had a home removal episode 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.
c. 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

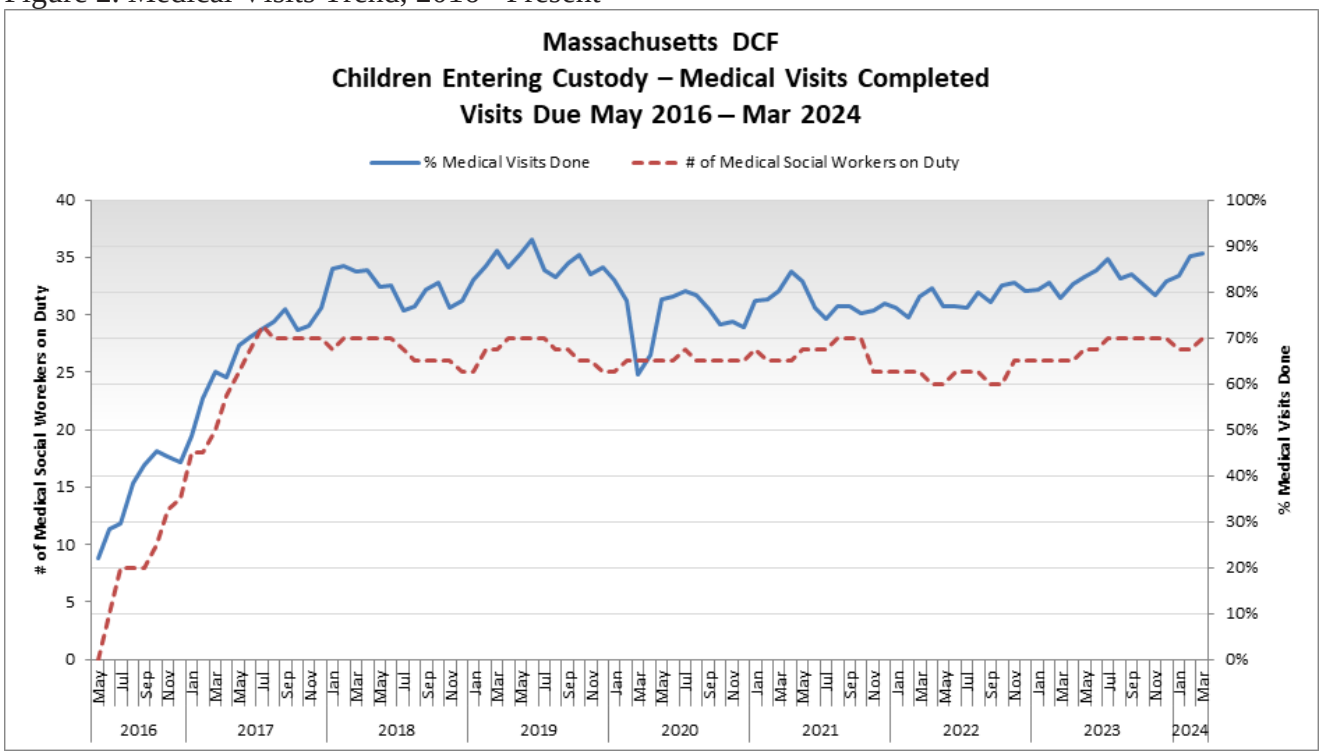
Draft for Policy Development Only — 5/23/2024

Monthly Compliance For Medical Screenings Due In March 2024

Run Date: 5/15/2024

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	8	7	0	87.5%	87.5%	16	6	9	37.5%	93.8%	54.2%	91.7%	10/1/16
Hyde Park	14	2	12	14.3%	100.0%	7	0	0	0.0%	0.0%	9.5%	66.7%	5/1/20
Jackson Square	9	1	4	11.1%	55.6%	10	1	4	10.0%	50.0%	10.5%	52.6%	2/1/20
Park St.	10	3	5	30.0%	80.0%	9	4	4	44.4%	88.9%	36.8%	84.2%	10/1/22
Boston Region	**41**	**13**	**21**	**31.7%**	**82.9%**	**42**	**11**	**17**	**26.2%**	**66.7%**	**28.9%**	**74.7%**	
North Central	17	7	6	41.2%	76.5%	10	4	5	40.0%	90.0%	40.7%	81.5%	6/1/16
South Central	36	33	3	91.7%	100.0%	17	16	1	94.1%	100.0%	92.5%	100.0%	6/1/16
Worcester East	10	8	2	80.0%	100.0%	13	10	3	76.9%	100.0%	78.3%	100.0%	7/1/16
Worcester West	11	8	3	72.7%	100.0%	14	5	5	35.7%	71.4%	52.0%	84.0%	7/1/16
Central MA Region	**74**	**56**	**14**	**75.7%**	**94.6%**	**54**	**35**	**14**	**64.8%**	**90.7%**	**71.1%**	**93.0%**	
Cambridge - Burlington	4	1	1	25.0%	50.0%	5	2	2	40.0%	80.0%	33.3%	66.7%	12/1/22
Cape Ann	3	1	2	33.3%	100.0%	3	2	0	66.7%	66.7%	50.0%	83.3%	1/1/21
Framingham	5	3	1	60.0%	80.0%	6	4	1	66.7%	83.3%	63.6%	81.8%	1/1/17
Greater Haverhill	9	2	7	22.2%	100.0%	13	12	1	92.3%	100.0%	63.6%	100.0%	5/1/23
Greater Lowell	25	10	15	40.0%	100.0%	7	2	4	28.6%	85.7%	37.5%	96.9%	
Lawrence	11	3	7	27.3%	90.9%	6	3	3	50.0%	100.0%	35.3%	94.1%	6/1/17
Lynn	15	10	4	66.7%	93.3%	4	2	1	50.0%	75.0%	63.2%	89.5%	10/1/23
Metro North	6	1	5	16.7%	100.0%	2	1	0	50.0%	50.0%	25.0%	87.5%	12/1/22
Northern Region	**78**	**31**	**42**	**39.7%**	**93.6%**	**46**	**28**	**12**	**60.9%**	**87.0%**	**47.6%**	**91.1%**	
Brockton	9	2	7	22.2%	100.0%	10	2	8	20.0%	100.0%	21.1%	100.0%	5/1/23
Cape Cod	3	2	1	66.7%	100.0%	2	1	0	50.0%	50.0%	60.0%	80.0%	7/1/17
Coastal	11	1	6	9.1%	63.6%	14	7	5	50.0%	85.7%	32.0%	76.0%	11/1/18
Fall River	14	10	3	71.4%	92.9%	15	8	4	53.3%	80.0%	62.1%	86.2%	6/1/17
Greater Waltham	8	5	2	62.5%	87.5%	4	2	2	50.0%	100.0%	58.3%	91.7%	4/1/17
New Bedford	5	5	0	100.0%	100.0%	9	9	0	100.0%	100.0%	100.0%	100.0%	6/1/21
Plymouth	11	2	9	18.2%	100.0%	8	4	4	50.0%	100.0%	31.6%	100.0%	11/1/16
Taunton/Attleboro	6	2	2	33.3%	66.7%	12	6	2	50.0%	66.7%	44.4%	66.7%	11/1/16
Southern Region	**67**	**29**	**30**	**43.3%**	**88.1%**	**74**	**39**	**25**	**52.7%**	**86.5%**	**48.2%**	**87.2%**	
Berkshire	7	0	5	0.0%	71.4%	15	8	6	53.3%	93.3%	36.4%	86.4%	8/1/17
Greenfield	8	0	8	0.0%	100.0%	2	1	1	50.0%	100.0%	10.0%	100.0%	7/1/23
Holyoke	7	6	1	85.7%	100.0%	9	6	3	66.7%	100.0%	75.0%	100.0%	1/1/23
Robert Van Wart	12	5	7	41.7%	100.0%	19	11	8	57.9%	100.0%	51.6%	100.0%	4/1/17
Springfield	11	3	6	27.3%	81.8%	11	3	4	27.3%	63.6%	27.3%	72.7%	5/1/17
Western Region	**45**	**14**	**27**	**31.1%**	**91.1%**	**56**	**29**	**22**	**51.8%**	**91.1%**	**42.6%**	**91.1%**	
Grand Total	**305**	**143**	**134**	**46.9%**	**90.8%**	**272**	**142**	**90**	**52.2%**	**85.3%**	**49.4%**	**88.2%**	

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, as well as a large number of pediatric primary care offices closing across the state which has led 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.

Jessica Coolidge, Statewide Medical Social Worker Specialist, is the hiring manager for these positions, 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 trainings 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 health care 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 analyst 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 trainings for medical providers and school nurses
10. Works with providers and provider agencies to support collaboration between DCF and the healthcare organization

Jessica works on large interagency projects and trainings which include the following:

1. Jessica Coolidge 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 related 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 prior to the April 1st changes, and with the support to the DCF Area Offices, this letter was sent to behavioral health providers to educate them of the pending changes which would impact access to care.

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

3. Jessica Coolidge has developed and been leading *Adoption and MassHealth* trainings for Adoption and ADLU teams across the state. This was developed due to an increase in post adoption calls and request for support, that Ms. Coolidge was receiving from across the state from adoptive parents needing assistance navigating the MassHealth system. Ms. Coolidge has 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. Jessica Coolidge provides training and support to Ascentria, the contracted agency who oversees the refugee minors living here in Massachussettes. Ms. Coolidge regularly assists these case managers and youth and young adults, on Medicaid navigation and barriers within the Medicaid system.

5. 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 who reach age 18 on or after January 1, 2023. Ms. Coolidge 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.

Ms. Coolidge has spoken at 2 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 – iFamilyNet.
- 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 agency database - iFamilyNet.
- Support agency staff with pharmacy issues, including Medication Administration Program (MAP) issues when youth are entering group home placements; follow-up on issues around 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 the development, revision and implementation of 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 trainings for Area Offices in regard to healthcare-related policies or directives.

Safe Sleep

Several medical social workers met with Dr. Sagor in 2019-2020 to discuss how to reduce unsafe sleep fatalities in the Commonwealth, many of which were open cases in the agency. Following a public campaign in 2018 with other sister agencies at Executive Office of Health and Human Services, this Committee was formed

to provide education and training to each DCF staff member through meetings at their area office. Between November 2019 and March 2020 four medical social workers, along with Dr. Sagor, completed an interactive presentation at seven area offices. These were well received and stimulated much energetic discussion. While several more presentations had been scheduled for late March and April 2020, they were cancelled at the outset of the pandemic. Two of the medical social workers had continued to attend meetings of this committee through 2022 and participated in developing trainings on this topic, including the development of the Kinship Orientation course curriculum on information on Safe Sleep. This contains videos overviewing Safe Sleep standards and scenarios. These courses will be available to all kinship/child-specific families when going through the licensing process in the near future. The Safe Sleep video will also be posted on FosterMA Connect for all foster and pre-adoptive families to access.

In 2024, the Child Welfare Institute has started to offer Safe Sleep training again to staff here at DCF. One of the Medical Social workers who previously had been facilitating these trainings, has taken on in partnering 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 practice in the first quarter of 2024.

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 a need for implants for missing teeth and orthodonture. Often teeth have been lost because of injury or lack of dental care prior to coming into care. Of note, MassHealth does not cover implants for any population. In 2019 and 2020, DCF met with the Delta Dental Foundation and the Wonderfund to secure pro bono support for orthodonture for children in custody who were not eligible for these services from MassHealth. As of March 2022, after the COVID disruption, DCF has restarted this work with Delta Dental foundation and MassHealth to find a solution for these issues. In 2022 Delta Dental provided a $10,000 donation to provide funds for specific cases. In addition to this donation three dentists in Massachusetts provided pro bono work for several youths, placing implants and crowns without cost and avoiding the need for dentures. We continue to work with Dr. Samantha Jordan, a public heath 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 been able to resolve several issues (delayed care, provider out-of-area, non-compliance, etc.) related to orthodonture. We are currently planning another meeting with Delta Dental, along with Wonderfund, to secure an additional grant as well as recruiting dentists to provide pro bono dental work when needed.

Nursing support

There are currently nine nurses on the medical team, which includes the nursing supervisor, five regional nurses, one nurse-liaison to Boston Children's Hospital, and two 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 Medical Director. Due to the expansion of the MAP program into additional programs across the state, we are currently recruiting for 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 trainings by subject matter experts at the meetings
7. Work with the DCF Child Welfare Institute to plan and implement medically oriented trainings for staff
8. Consult on healthcare/medical issues with DCF staff in 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 completes online applications. Well over 20 children have already received "Wishes" through this process and several are in process to get "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 that reviews any individual under age 22 for admission to a nursing home.

Regional Nurses

The Regional Nurses work in close collaboration and partnership with the integrated clinical practice teams in their Region. The nurse helps implement healthcare-related agency policy and provides consultation to DCF staff and to 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. Consults 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 of time
4. Coordinates healthcare services through communication with healthcare providers and hospitals, including assistance with hospital discharge planning
5. Participates in home visits as necessary to support DCF staff with obtaining/monitoring appropriate health care services for children
6. Reviews medical documentation related to payment of foster parents for care of children with special needs (PACT reviews)
7. 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
8. Assists with documentation of healthcare information in iFamilyNet and add healthcare-related documentation to the hardcopy case file
9. 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
10. Assists the HMST with trainings for staff and foster parents and helps coordinate trainings on healthcare issues with the Child Welfare Institute

11. Identifies children appropriate for HMST case conferences and participate in these meetings
12. 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
13. Utilizes the MassHealth system to research information necessary to respond to questions related to MassHealth eligibility, third party insurance, prior approval and claims
14. Works with the Supervisor to establish methods to document actual job responsibilities and measure satisfaction of DCF staff and implement the methods upon approval by the Supervisor
15. Assists with social work staff with assessing appropriateness of HIV testing for individual children
16. Provides monthly written reports and weekly e-mail or verbal updates to the Supervisor on consultation and other activities and ad hoc reports as requested
17. Consults with staff on cases before the Regional Fatality Review Boards
18. Participates in HMST meetings held at the DCF Central Office and meetings in the Regional and Area Offices as requested by the Supervisor
19. Participates in DCF Area and Regional Clinical Review Teams and monthly Special Kids/Special Care Case Review Team meetings
20. Participates in weekly or monthly meetings with certain hospital Child Protection Programs in the region
21. 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 the Foster Care Unit at the Central Office; and
22. Assists with the coordination of treatment plans for medically complex children who are transitioning into new foster homes, group homes and residential placements.

DCF Nurse Liaison (NL) at Boston Children's Hospital

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. The NL currently in this position is a former staff nurse at Boston Children's Hospital for many years and has extensive pediatric nursing experience and expertise with children who need tertiary care.

Special Kids, Special Care (SKSC) Program

The Supervisor of Nurses is the lead for 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, BMC Health Plan (BMCHP). 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. A child must be in DCF custody and in foster or group care when initially enrolled. If a child is subsequently adopted, in guardianship or returns to biological parent(s), 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, congenital anomalies, liver disease, renal failure, prematurity, spastic quadriparesis, encephalopathy, neurological disorders, cystic fibrosis, AIDS, 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. Currently 134 children are enrolled in the program.

Services provided by the program include:

1. A nurse case manager from BMCHP 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, 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 necessary 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 that is required for some medical equipment and services is not required.
8. A nurse case manager is on call 24 hours a day, 7 days a week.
9. 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.
10. 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.
11. 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.
12. For children transitioning to adoption, guardianship or biological parents, the nurse case manager:
    - Coordinates and arranges for 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
    - Is able to visit a prospective home to determine its appropriateness for meeting the child's medical care needs

<u>Complex Foster Care/Medical Program</u>

The Complex Foster Care/Medical program provides foster homes with caretakers who are skilled and trained to care for medically complex children and the program provides treatment supports 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 of age 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 nurse case manager.
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 Worker, and Consultant Psychiatric Nurse Practitioner 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 information for coordination and management of 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 MassHealth Managed Care Plan (about 20% of foster children), thereby allowing care coordination with the Managed Care Plan and its providers and the Massachusetts Behavioral Health Partnership.

5. The claims detail in the reports includes 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 transfers of medical data for children in DCF care or custody. These data pulls 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. Patient medical history, going back to October 2015, is included for all children currently in care or custody. The EOHHS data warehouse staff remains available to us 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 useful for further collaboration**.**

Data from MassHealth is stored securely in DCF's Oracle 12c database and can be linked to the DCF SACWIS and iFamilyNet 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)
- 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 iFamilyNet 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 iFamilyNet 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 important all psychotropic Medicaid claims into iFamilyNet 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.

Plans for coming year include:

- Continuing assessing 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 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 not possible, medical visits are scheduled with a health care provider close to the foster home or group care facility. At the outset of the pandemic many of these visits occurred virtually but most are now in person.

As noted above, if previous medical providers are not known to the Department, Cognos Medicaid reports can be pulled by multiple medical support staff in the agency to provide this information for children receiving MassHealth services.

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

There are two foster care clinics in Massachusetts, both associated with pediatric departments at academic medical centers (University of Massachusetts Medical School and Boston Children's Hospital). Both clinics ascribe 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 these clinics to ensure that children get their initial screening and comprehensive visits in a timely manner.

IV. Oversight of Prescription Medications

Youth in state custody have two psychotropic oversight processes to ensure 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 medications regimens for all youth on MassHealth, including youth in state custody. Medications regimens that include polypharmacy (four or more psychotropic medications), age restrictions (all psychotropic medications for youth less then 3yo, all psychotropic medications except stimulants and alpha agonists for youth less then 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 prior to the medication being filled at the pharmacy. The highest risk medication regimens receive a 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, as well as 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, Guardian Ad Litem (GAL) is appointed by the judge 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 has now expanded statewide in 2024. The AMP program provides medical review of all new requests for antipsychotic medication to help inform the court around 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 with coordination and communication 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 medical system. The DCF Child and Adolescent Psychiatrist (CAP) reviews all requests for antipsychotic medication to assess for appropriateness. If there are concerns around the high-risk prescriber the DCF CAP will complete a doc to doc with the prescriber to outline concerns and treatment recommendations.

The AMP program also has 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. Our hope is 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. This data is reviewed by the consultant child psychiatrist to look at any trends or 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 form called the "Dear Dr Letter". Regional Nurses provide initial review of psychotropic medication consent forms. If there are any questions or concerns with a medication request, Regional Nurses and send the Dear Dr Letter to the Psychiatric Consultant Nurse Practitioner for review and/or Consultant CAP at Central Office.

Plans for coming year 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

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 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 not possible, medical visits are scheduled with a health care provider close to the foster home or group care facility.

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

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

There are two foster care clinics in Massachusetts, both associated with pediatric departments at academic medical centers (University of Massachusetts Medical School and Boston Children's Hospital). Both clinics ascribe 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 these clinics to ensure that children get their initial screening and comprehensive visits in a timely manner.

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 the guidelines of MAP policy and procedures. MAP is implemented through uniform, statewide standards that undergo continuous evaluation and improvement. MAP Director, Eric Volz-Benoit is responsible for the oversight and implementation of Medication Administration Program for DCF with the assistance of DCF MAP Coordinator Jaime Allard-Smith. 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)
- Provide technical assistance to DCF in relation to MAP, as well as supporting 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, verification of tests, creation and revision of 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, as well as 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 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
- Collaborate COVID response and recommendations with vendor programs and DCF staff
- 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.
- 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 the course of six months, ERG surveyed other states' forms of medication administration, as well as Massachusetts MAP Certified Staff and vendor programs. Since the release of the ERG report, 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 in a way that could enable more staff to become MAP Certified and maintain that 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 on how to determine 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 evaluation of each suggested category in the ERG Report. Each sub-committee meets every two weeks to discuss 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 roll out 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 the process of 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 trainings 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, and 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

Medical Director, consulting child psychiatrist and medical team provide training to new DCF social workers as well as newly promoted staff (supervisors, area program managers) on medical protocols, medications, when to consult, and most recently, on all COVID issues.

Children's Hospital in Boston and UMass FaCES (Foster Children Evaluation Services) Clinic provide training for DCF Social Workers and periodically provides additional workshops/in-service training opportunities on selected medical topics. In addition, staff from Children's Hospital provides training for all DCF investigators on 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 make a recommendation to the Commissioner, Deputy Commissioners and the General Counsel for review of the proposed recommendations. If approved, the Department seeks a judicial determination on the decision. The Regional Nurses facilitate 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 order 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 provide training to new social workers and investigators on assessment of non-accidental trauma. Regular meetings between HSMT and CPT staff

statewide are held on a regular basis.

Gender Affirming Medication Consent Policy

In response to increasing numbers of requests for consent for gender-affirming medication (puberty blockers and hormones) from pediatricians at clinics evaluating youth with gender dysphoria, the Department has developed and implemented (September 2021) the Gender Affirming Medication Consent Policy provide guidelines to DCF staff and the medical community about specific information needed to consider when consent should be given. After the approval of the policy in September 2021, trainings were held in area offices as well as at an LGBTQIA+ liaison statewide meeting in March 2022. There is currently no similar policy in any state or county child welfare system in the United States.

All requests for gender-affirming care are reviewed by the medical director and the consultant child psychiatrist, to ensure the agency is doing right by the children and youth. Our consultant psychiatrist speaks personally with the mental health professional who knows the child best, in order to ensure best practice. Children in our custody must demonstrate 6-12 months of stable mental health prior to our consenting to treatment.

Dr. Sagor, along with two colleagues, talked about this policy as part of a presentation on "How to Create a Gender-Affirming Child Welfare office" at the Child Welfare League of America conference in Washington DC on April 25, 2023.

Over the past year, the number of children seeking gender affirming care has increased. Because all children in our custody have a trauma history, we are considering updating our policy to require a comprehensive, trauma-informed mental health evaluation prior to consideration of puberty blocking medications. Currently the policy requires such an evaluation for hormone treatment only.

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 consulting child psychiatrist to provide consultation 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 who have expertise in the mental health system and provide support to Area Office's 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 Specialist work closely with both DCF Child Psychiatrist and DMH Area Child & Adolescent Psychiatrists in order to ensure youth are receiving appropriate mental health supports to support appropriate placements.

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 but the Department must, beginning 90 calendar days prior to discharge and case closing, provide a transition planning process in collaboration with the youth/young adult, based on an assessment of her/his readiness for living interdependently in the community, age and follow up supports. The discharge and transition planning process must include a discussion of the youth/young adult's education, employment or work skills development, housing, 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 must be reported in any Permanency Hearing Report filed with a court after the youth/young adult turns age 17 years and nine months old. Any outstanding life skills needs are prioritized and addressed prior to discharge from placement and case closing. The Department must also provide written notice to the youth/young adult at least 30 calendar days prior to the anticipated date of discharge from placement and case closing (which may occur later). The scheduling of both steps should be planned.

- For the youth who intend to leave Department care or custody on her/his 18th birthday, the discharge and transition planning must begin 90 calendar days prior to 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 prior to her/his 18th birthday. The notice must contain notice of the right of the youth to challenge the discharge from placement and the closing of her/his 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 within 90 days prior to the closing date. The dates for discharge from placement and case closing should be reflected in youth readiness assessment tool if 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 prior to the date of the discharge from placement or case closing accordingly

- Please see section above re: SUPPORT Act for current initiatives related to health care for youths again out of care.

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 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 colleague who is compassionate, a creative problem-solver, and community-minded, evidenced by more than 15 years serving as the consultant pediatrician to the Boston Baseball Camp and the Franklin Park Coalition Youth Programs. Dr. Costello will be based at Central Office while 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 Professor of Pediatrics at 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 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 is Co-Program Director for the FaCES Safe and Sound clinic at UMass Children's Medical Center, which is an integrate behavioral health clinic for youth as they enter foster care. Dr. Morgan also is the Consultant Child Psychiatrist for the Department of Children and Families Office of the Medical Director and helps to lead psychotropic oversight efforts for youth in foster care across the State of Massachusetts.

Since joining the DCF Heath and Medical Services Team in 2016, Dr. Morgan has worked to ensure 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 appropriate use of antipsychotic medication for youth in state custody called the Antipsychotic Medication Monitoring Program that 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 of this committee 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. Dr. Morgan also received the inaugural Marilyn Benoit Child Maltreatment Mentorship Award from AACAP in 2018 related to her work within the child welfare system.