FFY 2025-2029 Child and Family Services Plan

Health Care Oversight and Coordination Plan

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Name: Linda Dettmann
Title: Program Manager
Address: Iowa Department of Health and Human Services
Division of Family Well-Being and Protection
321 E. 12th Street
Des Moines, IA 50319
Phone: 515-377-0324
E-Mail: ldettma@dhs.state.ia.us

IOWA Health and Human Services

Strategies for 2025-2029

- **Develop and roll-out a new CCWIS system. HHS commissioned a workgroup in January 2021 to start the work in designing and developing Iowa's CCWIS. As of July 2024, Iowa has decided to pivot from in-house development of the new CCWIS and shift towards outsourcing this initiative. The preliminary steps have been established and the work that has been done already will help to inform next steps. This new system will reduce inefficiencies in documentation and improve access to essential information, including Medicaid data, educational information and behavioral health services. With the aligned systems, HHS will have access to additional data that will help with the ongoing monitoring of health care needs.**
- **Roll out an informed consent process for Psychotropic Medications to include clinical consultation resources.**
- **Agency realignment will help to increase collaboration between Medicaid, Behavioral Health and Child Protective Services to ensure youth placed in care received the right level of services in a timely matter.**
- **Round 4 case reviews will continue assessing performance for both physical and dental health and will utilize a larger sample in order to more accurately generalize data to this population.**
- **Expand the University of Iowa's Complex Care Clinic for Youth contract.**
- **Expand the Therapeutic Foster Care Program to include more Service Areas.**
- **Continued work to improve the quality of home and community-based Medicaid services and supports for children and youth with serious emotional disturbance (SED) through the HOME project.**

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

If a child coming into care has not had a physical health screening prior to placement, scheduling of the initial physical health screening occurs within 14 calendar days of the child coming into care. After the initial physical, children in foster care have physicals on an annual basis, or in accordance with applicable Medicaid periodicity schedule for health exams, according to the age of the child.

The Department is responsible for the cost of medical care for children in family foster care placement. When the cost is not covered by the state Medicaid program, the cost may be paid through foster care funds. Each child shall be under regular medical and dental supervision. The child's latest health records are a part of the child's case plan. The social work case manager is responsible for ensuring that the foster parents know how to obtain medical care for the child, including:

- How to find a provider that accepts Medicaid;
- What the Medicaid program covers;
- How to access transportation for medical care;
- What periodic screening is required for children on Medicaid.

The social work case manager must ensure that a child in foster care receives proper medical care including:

- Periodic medical examinations by a physician, a nurse practitioner, or a physician assistant working under the supervision of a physician. Annual medical and eye exams and six-month dental and ear exams are required.

The shortage of pediatric dental services that accept Title IXI insurance is a known gap in Iowa that

continues to be addressed through I-Smile | Health & Human Services (iowa.gov). Legacy Public Health contracts with Medicaid to help fund I-Smile. I-Smile is the oral health component of the statewide Maternal Health and Child and Adolescent Health programs, managed by Iowa HHS. The program employs navigators who work to connect Iowans to needed dental services.

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

Children have a physical upon removal with a medical professional, which identifies their health needs including emotional trauma associated with their abuse and removal from the home. Social Work Case Managers (SWCMs) engage medical professionals in screening for the child's health needs. Considerations include but are not limited to:

- What behaviors are we seeing?
- Do they need behavioral health intervention services (BHIS)?
- What does the needs assessment tell us?
- Why is HHS involved with this child and family?
- What issues for specific children are noted and from what source, i.e., caregiver, family centered services (FCS) provider, HHS, therapist, or the child him or herself?

All of this information helps to determine the child's treatment plan. SWCMs rely on the child's medical professionals' expertise and recommendations for treatment.

SWCMs monitor the child's health care needs identified in the child's screenings, through documentation of medical care received and the effectiveness of their treatment plan, including appropriateness and sufficiency of the therapeutic services for meeting their needs. The SWCM monitors the child's health care treatments and therapy by reviewing the foster parent's documentation and the foster group care provider's health reports sent to them, and through discussions with the child and foster care provider. All of this information is documented in the child's case plan.

As seen in the case review data section of the CFSR, performance on this item has fluctuated, with most recent performance reported at 52% for calendar year 2023. Analysis of the detail data on this item indicate Iowa performs at approximately 92% in the areas of assessing physical health needs and providing appropriate services to children in care; the challenge tends to be with dental health assessment (67%) and services (46%).

Iowa is actively pursuing strategies to broaden the service array and access to appropriate services specific to children's needs, thereby diverting placements not equipped to meet these needs. A process to establish a Behavioral Health Services System in Iowa supported by the governor has recently been approved. This will combine existing mental health, substance abuse and other recovery services into one system. As of July 1, 2024, Iowa HHS announced a new Behavioral Health Service District Map which defines seven geographic service and planning areas. The district map was created using a data-driven approach to ensure that resources are allocated effectively to support the full array of behavioral health needs in Iowa. The new districts consider equitable resource distribution, minimizing service disruption, enhancing access to quality care, and addressing the specific needs of specific populations. The district map is a first step in building a new geographic foundation for an integrated and efficient behavioral health system that serves all Iowans. This work will continue throughout the next several years.

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

Most health care providers have electronic medical records. The foster care provider may ask for a "summary of the visit" or discharge/referral form at the end of the health care visit if it is not automatically provided. If the health care provider does not have electronic medical records, the foster care provider can give the provider the Physical Record, Form 470-0580, and request it be completed and returned to them. The Physical Record form includes a list of previous diseases that can be checked and dated, chronic illnesses and an area to list medications prescribed, physical examination information including vision, hearing, dental and mental health, and an area to complete preliminary diagnosis and recommendations, including any recommendations for further assessment or evaluation. The foster parent provides the Physical Record form, "summary of the visit", and other additional documentation of the child's health care to the SWCM.

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

The Iowa Department of Health and Human Services (HHS) continues to work on assuring that the health care records follow the child when they move to another placement outside of their medical home or leave foster care. Several options have been explored by the Psychotropic Medication Advisory Committee over the last two years. However, the nature of our systems has been a challenge on all sides. Currently, our systems are not connected or updated enough. As our new comprehensive child welfare information system (CCWIS) is built out we will continue to evaluate these options.

The Integrated Health Home (IHH) continues if the MCOs approve it. An IHH is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience. Children with a SED and their families receive IHH services using the principles and practices of a System of Care model. The IHH serves individuals enrolled in Medicaid, which includes those receiving targeted case management (TCM) and case management through Medicaid-funded habilitation as well as those not currently receiving care coordination. There have been adjustments made to IMPA which allows for both the MCO and HHS case managers to obtain contact information on one another.

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

Medication monitoring at the agency level

The HHS Bureau Chief for Service Training and Supports is currently working on a data sharing agreement to allow an exchange of a considerable amount of Iowa Medicaid data which includes psychotropic medication data for our new CCWIS system. The data sharing agreement is almost finalized and is currently in the signoff routing through leadership. Once this has been completed, Iowa Medicaid will be developing psychotropic medication reports for HHS ongoing. This is expected to occur in the next month. The Iowa Medicaid Warehouse was previously sending reports to HHS and JCS, however this stalled out over the last year. Additionally, HHS previously worked with Iowa Medicaid regarding data and process for the monitoring of psychotropic medication for the children and youth in foster care. Iowa Medicaid developed a metric for measuring child psychotropic use in foster care and added it to their overall strategic plan for HHS. This will allow for data information sharing regarding percentage of children and youth in foster care prescribed psychotropic medication, related demographics, and additional red flag practices. HHS anticipated that development of a process for Iowa Medicaid to communicate that information to HHS would occur over SFY 2021. However, this process was more complicated than anticipated and has stopped until CCWIS is able to work directly with MCOs. Iowa Medicaid added performance measures to the SFY 2021 MCO contracts that address outcomes regarding the use of psychotropic medications in children on

Medicaid. While HHS does not yet have access to that data, the performance measures on a systematic MCO outcome level should assist with prescriber level concerns. The Psychotropic Medication Advisory Committee attempted to work on getting better data, however obtaining data has been a challenge due to system issues. HHS anticipates that the new CCWIS system will help. This is expected to be deployed over the next two years.

HHS has also been selected to participate in the ASPE (Office of the Assistant Secretary for Planning and Evaluation) CHILDREN Initiative. The objective of this initiative is to enhance the data infrastructure and analytic capacity of child welfare and Medicaid agencies to support the implementation of the Family First Prevention Services Act (FFPSA). The top priority use case that the Iowa workgroup has identified for this initiative is ensuring the appropriate use of psychotropic medications for children in foster care. Iowa plans to link several types of Medicaid data, including eligibility and claims data, and child welfare data, such as placement and services data. These data will be used to conduct a variety of analyses designed to better understand the frequency and circumstances in which psychotropic drugs are being prescribed for children in foster care. The linked data infrastructure will exist within the planned shared data lake for child welfare data, where Medicaid data will be linked with CCWIS through data exchanges. This data could be used for several purposes, including enabling alerts to case workers, monitoring whether children are receiving needed services, reviewing the continuity of care children receive in the child welfare system, and improving the ability to identify, report, and share data on the FFPSA population.

Medication monitoring at the client level

Foster parent level: HHS works with the five service area recruitment, retention, support, and training (RRTS) providers to provide training to foster parents on medications:

- understanding what the medication is;
- what the medication is used to address;
- possible side effects of the medication;
- when to contact the child's doctor if there is a problem with the medication or the child's reaction to the medication;
- description for what a psychotropic medication is;
- when to contact the child's SWCM;
- possible alternatives to medications; and
- how the foster parent can advocate for the best interest regarding the child's health care needs.

Foster parents are part of Iowa's collaborative team in monitoring medications and the health care needs of children in foster care. The foster parent monitors for side effects and contacts the prescribing doctor if there are side effects or the medication does not address the issue for which it was prescribed. The foster parent also keeps the child's case manager informed of the medications and any issues with it. Additionally, some HHS SWCMs go with the foster parent when the child goes to their health care provider.

SWCM level: Staff has the responsibility to ensure the mental health needs of children in out-of-home care are met, including the oversight of medication prescribed for mental health. Appropriate oversight includes, but is not limited to:

- Ensuring that a child regularly sees a physician or psychiatrist to monitor the effectiveness of the medication, assess any side effects and/or health implications, consider any changes needed to dosage or medication type, and determine whether medication is still necessary and/or if other treatment options would be more appropriate.

- Regularly following up with foster parents/caregivers about administering medications appropriately, and about the child's experience with the medication(s), including any side effects.
- Documenting in the child's case plan the child's mental health diagnosis and medication list including date prescribed.

Oversight of the medication by the worker requires teamwork, including coordination and communication amongst caregivers, service providers, parents, medical/mental health providers and, when appropriate, the child. HHS encourages parental involvement in decision-making to the greatest extent possible. The worker documents in the case narrative if the medication is working well, if there are any side effects, or if the child or others report concerns about the medication. Workers may also consult the child's physician, pharmacist, or the National Institutes of Health's Drug Information website. In addition, if appropriate, the worker advocates on the child's behalf to have the medications reviewed by the physician and explore alternatives.

The Drug Utilization Review (DUR) Commission examines the use of multiple antipsychotics and sends notification letters to prescribers and pharmacies stating they identified a member as having a drug related issue and makes a suggestion regarding medication therapy. Currently, based upon 6 months of pharmacy claims data, the DUR Commission sends the provider notification letters only to Medicaid fee-for-service providers. The DUR Commission sends these letters to providers that meet a certain set of criteria, either through regular profile reviews (which consist of 1,800 profiles over a 12-month period) or a targeted intervention (specific population, member count varies). The DUR does not send letters to all prescribers who prescribe two or more psychotropic agents simultaneously. Additionally, the DUR reviews the profiles of 300 members (of all ages) identified with the highest level of risk for a drug related issue at each meeting; a small portion is for children for whom not all are on psychotropic medications.

Shared Decision-Making (Informed Consent and Assent)

HHS has been reviewing policy, practice, and procedure around informed consent and assent for the prescribing of psychotropic medications for children and youth in foster care. A workgroup was formed on the Psychotropic Medication Advisory Committee. One of the objectives for this workgroup was developing a consent for psychotropic medication form to document diagnosis, proposed medication, expected benefits, possible risks/side effects, red flag information, and alternate treatment options. Signatures on the proposed form would indicate that review of the above information occurred with and consent obtained from the parent or legal guardian as well as assent obtained from the youth. A draft Informed Consent/Assent form has been developed by the committee and was sent out to internal and external stakeholders for feedback. At the end of the form is a section titled "Criteria Warranting Further Case Review." This section lists six criteria that indicate further review when a psychotropic medication is prescribed. These criteria do not necessarily indicate that psychotropic medication treatment is inappropriate, but they do indicate a need for further clinical review. Currently, the HHS Child Protective Services (CPS) team does not have anyone with the expertise to provide the clinical review of these medications. The CPS team is exploring options for a clinical consultant by having conversations with the State Medical Director, Dr. Robert Kruse and Iowa Medicaid Director, Elizabeth Matney. There have been discussions regarding next steps in a potential process in mapping out the clinical review when these criteria emerge. HHS expects to have this process in place over the next year. The Informed Consent form has not yet been implemented. We are getting closer to rolling out the form and training staff as the workgroup has now developed a workflow process when secondary clinical reviews are needed.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

All children in foster care enrolled in Medicaid are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Iowa has an EPSDT Care for Kids stakeholder workgroup comprising representatives from Iowa Medicaid, Iowa Department of Public Health, managed care organizations (MCOs), and the University of Iowa. This workgroup focuses on the benefits, coverage, and education around the EPSDT for all Medicaid children.

Iowa Medicaid completes the required annual EPSDT Participation Report that reflects all eligible participants. However, the Report does not delineate the foster care population. The last annual EPSDT report was for fiscal year 2017. This report shows all eligible individuals for EPSDT, the state periodicity schedule, age groups, the expected number of screenings per eligible and total screenings received, categorized into two eligibility groups of Categorically Needy (CN) and Medically Needy (MN).

How Iowa actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.
HHS SWCMs assess the physical, dental, and mental health, and substance abuse needs, if applicable, of children in foster care. SWCMs consult with physicians or other appropriate medical or non-medical professionals for initial and ongoing medical exams, mental health evaluations, substance abuse evaluations, and necessary follow-up treatment, if determined needed by the health professional. HHS SWCMs also participate in Member-Centered Meetings (MCMs) with HHS field operations support unit (FOSU) staff, Iowa Medicaid staff, HHS Mental Health and Disability Services (MHDS) staff, and medical professionals to discuss complex cases in an effort to ensure that children in foster care receive the most appropriate services for their needs. SWCMs submit a request for a MCM, which includes the following information in the request:

- Name of child
- State ID
- Date of birth
- Summary of the child's current situation and the purpose of the call. (Please keep in mind that the calls are not intended to discuss funding issues, level of care decisions, etc. The call's focus is on the need for case management and assistance in setting up services to support the child and family.)
- List of names, phone numbers, and email for each of the individuals invited to the call.

The SWCM sends the request directly to the MCO. A dedicated staff person located in the Bureau of Service Support and Training offers to sit on the calls. Some of the common reasons for calls are questions about waiver programs and youth eligibility, hard to place youth and needed placements, and services for youth in and out of the home.

The procedures and protocols the State established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.
When children placed in foster care come into the child welfare system, SWCMs look for the nearest care provider in order to continue their medical home and their existing treatment plans. HHS staff completed and submitted pre-file language for the Iowa 2019 legislative session, to include in the child's case plan documentation of:

- Efforts to retain professional providers for children entering/in foster care and
- Activities to evaluate service needs in order to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities.

The 2019 legislative session resulted in amending Iowa Code § 232.2, Definition of "case permanency plan" to add plans for retaining any suitable existing medical, dental, or mental health care providers of the child when the child enters foster care. House File 644 also required HHS to amend its administrative rules. The administrative rules provide that a case permanency plan for a child placed in foster care shall include information describing efforts to maintain suitable mental health care and medical health care for the child to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities. In January 2020, HHS submitted an amendment to IAC 441-202.1(234) to add the following language to the definition of case permanency plan:

> *"this includes information describing efforts to retain existing medical and mental health care providers for a child entering foster care and activities to evaluate service needs to avoid inappropriate diagnosis of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities."*

The Iowa Administrative Rules Review Committee adjusted its work in response to the Coronavirus pandemic, which delayed enactment of the administrative rule change. This rule was enacted effective 1/1/21. Prior to the enactment of this rule, HHS added an emphasis on keeping children with their current health care providers to mitigate misdiagnosis to the case plan in conjunction with the changes made to the case plan for transition planning noted below. For example, HHS added the following question on the Health records section of the Records tab:

- "Was the child able to maintain current health care provider (mental, physical, dental)?"
    - "If no, describe efforts made to maintain continuity of care":

The Therapeutic Foster Care (TFC) Program began its pilot in the fall of 2023 in the Cedar Rapids Service Area. TFC promises to identify children ages 8 through 12, in or entering the foster care system who have need for a highly structured out of home placement environment, who do not require residential or hospital care. Children in TFC receive daily care, guidance, and modeling from specialized, highly trained, and skilled foster parents. TFC resource parent(s) receive support and supervision from private foster care agencies with the purpose of stabilizing a child's mental/behavioral health issues, facilitating children's timely and successful transition into permanent placements, and achieving individualized goals and outcomes based upon a comprehensive, multifocal care plan. The TFC program emphasizes that if a relative or fictive kin can care for the child and meet their needs, TFC is not appropriate, and the focus should be on working toward the kin placement and what supports or services are needed for that placement. The program emphasizes Medicaid home and community-based services (HCBS) to support foster care youth at high risk for institutionalization or multiple placements. The TFC program will continue to be evaluated over the next five years to determine if the eligibility criteria needs to be adjusted and if the program is meeting the needs of the youth being served.

HHS has also recently hired 5 Complex Case Managers (CCMs) to assist with our complex need cases in each of our 5 Service Areas. These positions will support our SWCMs in maintaining youth with complex needs at the lowest level of care possible. They will address youth with high acuity needs and assist in getting these youth the right level of services and supports. These positions will continue to be evaluated and built out in order to meet the unique needs of our most acute and vulnerable youth over the several years. A cross-collaborative initiative that was rolled out recently and will be continued to be evaluated over the next five years is the Children's SWAT. This meeting allows for HHS to staff our highest need youth with all different manner of providers in the child welfare, Medicaid, and behavioral health spaces. The primary objective of this meeting is to facilitate urgent placement needs for individuals in Iowa.

HHS and Iowa Medicaid worked together to contract with the University of Iowa to complete Complex Youth Care Assessments. The number of youth with complex needs has significantly increased in our state. In order to better serve these youth, the University of Iowa developed a Complex Care Clinic for Youth (CCCY) to specifically benefit youth receiving child welfare services. The University of Iowa will be providing specialty medical services for complex youth under the care of HHS. There is a workgroup talking through this process which meets monthly. The University of Iowa began taking referrals on February 1, 2024. The University of Iowa will identify and arrange appropriate medical assessments for the youth and provide assessment information to the youth and their caregivers, including recommendations for ongoing services. Once the assessments are complete, a staffing will be held with the family, youth, HHS staff, & MCO to summarize the care plan. Some of the reasons for an assessment referral may include:

- Unclear health status in the setting of neglect or abuse
- Mood or anxiety symptoms
- Disruptive behavior symptoms
- Unusual/odd behaviors present over time (not on an isolated basis)
- Problems with eating/growth
- Concerns for harm to self or harm to others on a chronic basis, not including acute needs
- Poor adaptation to living situation changes occurring during HHS involvement
- Poor academic or behavioral performance

The HOME (Hope and Opportunity in Many Environments) Project by Iowa's Behavioral Health Services Division is working on investigating the community-based service (CBS) needs of three populations of concern and provider capacity to serve them in the least restrictive setting. One of the populations is children and youth with serious emotional disturbances (SED). The current Home and Community Based Services System has several challenges that include waitlists are not timely, efficient or needs-based, services do not align with Iowan's needs, and services and supports are difficult to navigate and access. Some of the recommendations to improve this system are; develop a single waitlist that allows Iowa HHS to understand needs and prioritize waiver slots, transition to a waiver system that is need-based, person-centered and equitable, expand service offerings to address the whole person, use tiered budget levels to more efficiently use limited funds, develop a system that is easier to understand and navigate, and use blended provider networks to maximize capacity. The HOME Guiding Principles are Equitable Access, High quality service, Coordinated systems, Proven valuable services, and Effective and accountable system. They are looking at a Proposed Waiver Redesign, changing from 7 waivers to 2, age-based waivers. Waiver 1 would include Children and Youth (ages 0-20). The groups served under this waiver would include youth with an intellectual disability, brain injury, AIDS/HIV, physical disability including blindness, SED, and Developmental Disabilities. The proposed timeline for the waiver redesign is October-December 2024, submit waiver applications to CMS and begin implementing redesigned waivers by July 2025. The timeline is contingent upon ongoing support from the Iowa Legislature and federal review, support, and approval.

Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met. Iowa utilizes the streamlined procedure for youth automatically continuing on Medicaid; used previously for the Medicaid for Independent Young Adults (MIYA) program (reviewing first for any other Medicaid coverage groups the youth may be eligible for), once their foster care case closes. Extended Medicaid for Independent Young Adults (E-MIYA) uses a passive annual review to ensure location of the participant and any changes in household, which may make the participant eligible for other Medicaid coverage groups rather than E-MIYA.

The HHS transition planning specialists train workers on educating youth on the review procedure prior to discharge from care. Additionally, Aftercare workers and foster families received information on the procedure to assist those youth on their caseload with the review process. HHS stresses the reapplication process in new worker training. Youth automatically placed on E-MIYA or any other type of Medicaid coverage group at the point of discharge receive a letter from HHS explaining the Medicaid coverage and the renewal process. Staff are trained to tell youth to contact HHS or the Iowa Aftercare Services provider if they receive paperwork they need help with after discharge.

For any youth aged 14 or older the Transition Plan Tab on the case plan must be filled out. This tab includes information on all of the above requirements. Iowa has an electronic tracking system for transition planning activities to ensure youth aged 14 and older in foster care as well as young adult foster care alumni get the support they need and that HHS remains in compliance with all requirements for case planning of transition aged youth. The purpose of the foster care transition program is to assist youth in acquiring skills and abilities necessary for transition successfully to adulthood. Under Iowa's Transition Planning Program, services are available to all youth in foster care who are 14 years of age and older and youth adopted or who enter Subsidized Guardianship from foster care at age 16 or older.