

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

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

- A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
- How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child’s maltreatment and removal from the home;
- How medical information for children in care will be updated and appropriately shared, which may include developing and implementing an electronic health record;
- Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care;
- The oversight of prescription medications, including protocols for the appropriate use and monitoring of psychotropic medications;
- How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children;
- The procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses; and
- Steps to ensure the components of the transition plan development process required in 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.

Schedule for Initial and Follow-Up Health Screenings

The health of a child in out-of-home care is of paramount importance throughout the child’s placement. Children’s Division shall maintain best practices in monitoring the child’s health as required by federal and state laws, and as recommended by the American Academy of Pediatrics (AAP) and the Child Welfare League of America (CWLA), which set forth certain medical appointments occur timely and at specified intervals to assess and monitor the child’s health.

Those include:

Initial Health Examination: Each child entering out-of-home care shall receive an initial health examination within 24 hours to identify the need for immediate medical or mental health care, and to assess for infectious and communicable diseases. When possible, this exam should be completed by the child’s current primary care physician as they are already familiar with the child’s medical history. If a provider is not readily accessible, this exam must occur no later than 72 hours from initial placement. The assigned case manager should obtain documentation of the results of the assessment

within 72 hours of the appointment and ensure compliance with any recommended follow-up treatment/interventions, including further assessment for trauma.

Full HCY Evaluation: A full EPSDT screening, known in Missouri as the Healthy Children and Youth (HCY) evaluation, including a physical examination, and other developmental components, including but not limited to vision, hearing, social/emotional and dental screenings, shall be completed no later than 30 days after the youth is placed in Children's Division custody. Staff is required to promptly follow up on any recommendations rendered from the evaluation, including more comprehensive assessment for trauma or other behavioral health services.

Ongoing Medical Examinations: Children in the custody of the Children's Division receive ongoing HCY exams in accordance with the periodicity schedule recommended by the AAP https://www.aap.org/en-us/Documents/periodicity_schedule.pdf:

Recommended Periodicity Schedule for HCY Screenings:		
Newborn (2-3 days)	15-17 months	8-9 years
By 1 month	18-23 months	10-11 years
2-3 months	24 months	12-13 years
4-5 months	3 years	14-15 years
6-8 months	4 years	16-17 years
9-11 months	5 years	18-19 years
12-14 months	6-7 years	20 years

Components of a Full HCY Screening Include:
<ul style="list-style-type: none">• Health and developmental history (both physical and behavioral health)• Complete physical exam• Health education• Immunizations and lab tests, as indicated• Lead screening and testing, as indicated• Developmental and mental health screening• Fine motor/gross motor skills screening• Hearing, vision, and dental screening

Dental Exams: All children receive dental *screenings* as part of the comprehensive assessment/HCY exam completed in accordance with the AAP periodicity schedule. As part of the HCY screening, the primary care professional, or other appropriately trained professional, performs an oral health screening of the child's mouth and teeth to identify oral disease or other oral conditions (delayed tooth eruption, premature tooth loss, trauma) and provides guidance for management. Primary care professionals identifying problematic oral health during the dental screening portion of an HCY exam will refer the child to a dentist for a complete dental exam.

Missouri Children's Division recently adopted the dental exam periodicity schedule recommended by the American Academy of Pediatric Dentistry which recommends the first dental exam occur at the time of the child's first tooth eruption, or no later than 12 months of age. Ongoing dental exams occur every six (6) months thereafter, or more frequently if recommended by the dentist based on the child's risk status.

Monitoring and Treating Identified Health Needs, Including Emotional Trauma

The Children's Service Worker is responsible for ensuring children in CD custody receive the appropriate screenings, assessments, and follow-up services and treatment as necessary. This is accomplished by collecting medical records, collaborating with the child's resource family around information sharing, the creation of oversight specialists, enhanced partnership with Managed Care Organizations, and increased staff involvement in informed consent decisions and treatment planning.

Family and Resource Parent Engagement / Information Exchange

Staff is required to obtain medical records for children entering care and ongoing throughout the life of the case. Health care records created prior to the child entering out-of-home care are requested upon entry and maintained in the child's case record through a document-imaging program. Health information is obtained from the child's family and relatives immediately upon entering care via the Child/Family Health and Developmental Assessment forms, CW-103 Attachments A and B. Staff is to continually engage families in obtaining health information for the duration of the child's placement in out-of-home care.

All children in care must have a 24hr initial exam as well as a comprehensive Healthy Child and Youth (HCY) assessment within 30 days of entering care. Documentation of both exams should be obtained promptly and, in discussion with the child's resource parent, any recommended follow up treatment should be arranged. The case manager is responsible for monitoring the child's treatment plans and ensuring all recommended treatment is received.

Resource parents report physical and behavioral health activity to the Children's Division through monthly worker/resource parent visits, as well as form CD-265, the Monthly Medical Log. The log provides monthly documentation of medical events (illnesses, allergic reactions, etc.), doctor visits, therapy sessions, informed consent decisions made for routine treatment only, medications list, and upcoming appointments. Staff are better positioned, as a result, to more effectively monitor the child's health and treatment needs. The transient nature of children in foster care makes this exchange of information vitally important. Each new resource family needs current and relevant health information, and they need it quickly, in order to provide the best care for children in their homes. The CW-103 Child/Family Health and Developmental Assessment form is provided to the resource family upon placement. Because this form reflects more historical information, the Health Care Information Summary (CD-264) was created in 2018 to highlight current and pressing health information one would need to know more immediately in order to provide necessary care for the child. The CD-264 is to be provided to the resource family upon placement and includes:

- contact information for all current physical and behavioral health care providers
- upcoming appointments
- current illnesses/health conditions presently being treated, treatment regimen and related follow-up
- chronic/reoccurring conditions requiring monitoring and treatment
- concerns for development currently being monitored
- current medications/dosages/reason
- allergies – including type, symptoms, treatment/action plans
- significant, relevant medical/behavioral health history
- other helpful information particular to the child – emotional/physical safety considerations, stability anchors, social connections

Trauma Assessment Pilot with a Managed Care Organization

Children's Division has worked diligently over the past few years to heighten staff's trauma awareness and sensitivity needed to serve families and children involved in the child welfare system. The capacity for all staff to screen clients for

trauma is a goal. With this must come staff's ability to be appropriately responsive to any traumatic experiences or triggers uncovered during such screening. The Children's Division is considering a number of trauma-specific assessment tools. Once selected, staff will be thoroughly trained on the tool's application and how to triage outcomes to best support families and children.

Meanwhile, one of the State's three Managed Care Organizations, United Health Care (UHC), approached Children's Division with a request to pilot a trauma assessment tool with children served in one circuit in the state. The MO HealthNet Division, who oversees the managed care contracts, and Children's Division sought to capitalize on the care management performance requirements included in the managed care contract that had been previously underutilized. The pilot proposal created the opportunity to access additional care management and oversight for children included in the pilot area while also administering needed trauma assessments that will inform better treatment plans for children in care, as well as help inform CD's next steps for a statewide trauma assessment protocol.

Children's Division and MO HealthNet approved UHC's selection of the CANS Trauma (Child and Adolescent Needs and Strengths Trauma version) provided by the National Child Traumatic Stress Network. UHC's care managers are trained on the CANS Trauma, how to administer it, and how the assessment can be used in subsequent treatment planning. With consideration given to circuit demographics and foster care entry rates, the 32nd Circuit – consisting of Bollinger, Cape Girardeau, and Perry counties – was selected for the pilot. The pilot began in early 2019 and includes all children who enter foster care in the 32nd Circuit and who are placed within the circuit. Data on the number of children assessed or the impact on treatment planning is not available at this time.

Informed Consent Policy Revisions

Informed consent policy revisions that went into effect September 1, 2018 delineate responsibilities and consenting authority between Children's Division/contracted case management staff and resource parents. Specifically, only CD/contracted case management staff is permitted to consent to non-routine treatments, which include the initiation of mental health services (behavioral therapy, psychiatric treatment, psychotropic medications). In order to weigh informed consent in these situations, the case manager must participate in the visit with the practitioner, age-appropriate youth, the resource parent(s), and the child's family, ideally. Participation in this initial assessment for services or pharmacological intervention allows the case manager to not only provide informed consent, when appropriate, but also to be part of the resulting treatment planning process. The case manager will have input into the treatment plan and will have direct knowledge of what monitoring and oversight is required by the plan.

Updating and Appropriately Sharing Medical Information, which may Include Developing and Implementing an Electronic Health Record

The exchange of medical information between the child's family, resource parents, and case manager is fundamental to ensuring the child receives appropriate and coordinated care. As noted above, the Child/Family Health and Developmental Assessment (CW-103) form is provided to the resource family upon placement. This form provides the most comprehensive historical information when parents are engaged in its completion. The form must be provided to new resource parents within 72 hours of placement and should be updated as new information is gathered. To provide resource parents with a child's current health status, the Health Care Information Summary (CD-264) was created in 2018. This tool was developed to complement the CW-103 by providing information a caregiver would want or need to know immediately about the child coming into their home, focusing less on historical medical and development information. The CD-264 shall be updated prior to each new placement and provided upon the child's placement. Additionally, the CD-265 Monthly Medical Log was initiated at the same time to serve as a means for resource parents to document all health care events for a child in their care. The log is to be provided monthly to the case manager and used to update the CD-264 when needed, and appropriate fields in the FACES Medical Information screen.

Policy requires staff to enter medical information in the child's FACES case record and to upload records into the FACES OnBase document imaging system. Document imaging allows the child's case record to be viewed by anyone with business-need access without access to the paper file. This is especially helpful when a child is placed outside his/her county of jurisdiction and is being serviced, in part, by a Children's Service Worker who doesn't have access to hard copies of the file. As well, document imaging provides ready access to specialized staff conducting case reviews or assisting in the oversight or monitoring of a child's health care.

MO HealthNet is collaborating with Children's Division to pilot an electronic health passport in the 12th and 13th circuits. Medical providers in the two circuits have entered into agreements with MO HealthNet for systems requirements that will work with the electronic passports/cards. The current plan is for out-of-home care staff in both circuits to begin user acceptance training in April, which is designed to test the FACES interfacing requirements for functionality. Staff will then receive training in May and begin piloting the electronic health passports thereafter. The pilot is expected to run for approximately 12 months and then be reviewed for possible expansion.

Steps to Ensure Continuity of Health Care Services, which may Include Establishing a Medical Home

Health Homes

In 2015, a health home model for children and youth in foster care was established in the St. Louis region to more effectively coordinate medical and behavioral health care for foster children. All children entering out-of-home care in the St. Louis region must be referred to one of the two health home providers for his/her 30-day comprehensive assessment.

Children under age 12 are served by the Fostering Healthy Children Program at SSM Health Cardinal Glennon Children's Medical Center in St. Louis. In addition to providing 30-day comprehensive assessments, the Fostering Healthy Children Program provides for foster children initial health exams upon entry into care, standardized developmental screenings, mental health evaluations, counseling recommendations, referral and treatment, and education regarding child development and issues specific to children in foster care. Cardinal Glennon gathers each child's medical history prior to the comprehensive assessment and then coordinates any recommended follow up care.

The Creating Options and Choosing Health (COACH) Clinic through Washington University in St. Louis provides foster youth ages 13-17 his/her initial 30-day comprehensive assessment. Served youth are also given the opportunity to participate in voluntary health education programs and have continuous access to medical care, psychiatric services, dental services, and case management.

Contracts for the two existing foster youth health homes have been extended. Statewide Medicaid Managed Care expansion went into effect May 1, 2017. In November 2017, MO HealthNet, in collaboration with the Children's Division, held a Youth in State Custody Summit with all three managed care plans and featured the foster youth health homes model as a best practice. The goal is to build on the care coordination responsibilities of the managed care plans and encourage the inclusion of foster youth health care homes or similar specialty clinics in the health plan provider networks. This will lead to better overall integration and care coordination and provide a path toward sustainability and expansion. In early 2019, MO HealthNet convened a workgroup in partnership with Children's Division to improve communication between the managed care plans and to expand the health homes model throughout the state. There is a significant amount of information yet to be determined, including the requirements of a health home, certification of providers, systems issues, transitioning youth out of care, preventing duplication of services, to name just a few.

Although not a formal health home contract with the Children's Division, a Memorandum of Agreement (MOA) was developed between Children's Division/Jackson County and Children's Mercy Hospital-Kansas City and fully executed in March 2019. The MOA was created to allow data sharing between the two entities in order to coordinate the required 24-hour initial physical exam for children entering out-of-home care in Jackson County. The agreement allows Jackson County CD to provide the Children's Mercy Foster Care Medical Unit the names and contact information for all new

entries into foster care. Children's Mercy will arrange for the child to receive his/her 24-hour exam at Children's Mercy, or by a provider arranged for by Children's Mercy staff to accommodate proximity or schedules. The FACES access granted to Children's Mercy through the MOA will provide case manager, supervisor, and resource parent contact information so Children's Mercy staff can relay more quickly outcomes of the initial exam and any follow up or service coordination needed.

Managed Care Plans – Care Management and Care Coordination

The new Managed Care contract released May 1, 2017 requires increased care management and care coordination for members. All children in foster care receive care management services through his/her managed care plan. The contract requires the primary care provider to maintain continuity of each member's health care and that they work with health plan care managers in developing plans of care for patients receiving care management services. In the event a child is transitioning to a different managed care plan, the contract requires the new plan to continue services authorized by the previous plan for up to sixty calendar days and precludes the new plan from reducing services until the new plan conducts an assessment supporting service reduction.

Care Management services are intended to improve patient care and coordination, improve health outcomes, reduce inappropriate services and inpatient hospitalizations, and to better educate providers and members. The health plan must work with the child's resource parents to ensure the child receives all required examinations and health care visits/interventions within the timeframes defined by Children's Division and determined by the child's needs, including all HCY/EPSDT well-child exams. The care management record documentation must include, but not be limited to:

- Referrals
- Assessment/Reassessments
- Medical History, including psychiatric and developmental
- Medical Conditions
- Psychosocial Issues
- Care Planning
- Provider Treatment Plans
- Testing
- Progress/Contact Notes
- Discharge and Aftercare Plans
- Coordination/Linking of Services
- Monitoring of Services and Care and Follow-Up

The health plan shall document the following information about children in foster care and provide to the state agency:

- The number of children eligible to receive the required health care visits (24-hour initial exam, 30-day HCY assessment, and subsequent HCY exams based on the child's periodicity schedule);
- The number of children who received the required visits within the required timeframe;
- Reasons why visits were not received within the required timeframe;
- The number of children who needed mental health services and the number who did not receive mental health services and the reasons why; and
- The most prevalent chronic diseases by age group.

A request for these reports from each of the three plans has been made to MO HealthNet which oversees the contract. The reports are not available at the time of this submission.

Oversight of Prescription Medications, Including Protocols for the Appropriate Use and Monitoring of Psychotropic Medications

MO HealthNet Clinical Protocols

Children's Division has worked closely with the MO HealthNet Division and Department of Mental Health to address the appropriate use and monitoring of psychotropic medications for children and youth in out-of-home care. The Children's Division, MO HealthNet, and Department of Mental Health worked together to create clinical protocols in the form of hard-stop edits in the MO HealthNet pharmacy system to monitor and limit psychotropics prescribed to children. These edits prevent prescriptions from being filled until a contracted board-certified child psychiatrist can conduct a review.

The Atypical Antipsychotic Clinical Edit, initiated in October 2010, originally required a review of all new and non-compliant requests for an atypical antipsychotic for all enrolled children under the age of five (5) before the prescription could be filled. The child and adolescent psychiatrist reviews the request to ensure appropriate diagnosis, metabolic monitoring, and co-occurring, evidence-based behavioral interventions are implemented. In late 2015, this edit was increased to include any child under age nine (9).

The second edit for five (5) or more psychotropic medications prescribed for children under age five (5), implemented in 2010, remains in effect with the same protocol for atypical antipsychotics. The MO HealthNet Division has also removed Oppositional Defiant Disorder as a qualifying diagnosis for children under the age of nine (9) years.

The MO HealthNet Division reports these system edits have contributed to a decrease in the number of requests from prescribers for an antipsychotic for a child under age nine. The requests the child psychiatrist is receiving are being approved at a higher rate, suggesting practitioners have changed prescribing practices.

Psychotropic Medications Monitoring Training

Children's Division collaborated with Department of Mental Health Chief Medical Officer, and board-certified child and adolescent psychiatrist, Dr. Laine Young-Walker who provided staff training on the appropriate use and monitoring of psychotropic medications for children and youth. The goal of the three-part series webinar training is to provide practical information on common classes of medications and best practice guidelines, including tips on monitoring psychotropic medications with youth and caregivers. Each of the three webinars highlights how to prepare for an appointment and what questions to ask the provider when giving informed consent. The webinars were presented in June, September, and November 2017. The webinars were also recorded and posted on the Children's Division intranet and internet websites so all staff, contracted case management staff, and resource providers can access. The webinars are a training requirement for current Children's Division staff and contracted case management providers.

Heightened Trauma Awareness for Resource Parents

In working toward becoming a trauma-informed organization, Children's Division is training resource parents on the National Child Traumatic Stress Network's Resource Parent Curriculum (RPC) *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents*. Some resource parents may have become too accustomed to seeking pharmacological interventions to address a child's behaviors. The new informed consent policy implemented in September 2018 requires that before a child is evaluated for psychotropic medication, they or their caregivers must first have attempted non-pharmacological interventions. Should these interventions prove ineffective or insufficient, the child may be recommended for a psychiatric evaluation if referred by a mental health professional. This policy revision reinforces the need to strengthen resource parents' readiness to meet the unique needs of children in foster care. The eight-week RPC workshop prepares resource parents to understand how trauma affects children so resource parents, in turn, are more skilled and effective in addressing behavioral symptoms in the home. Understanding behaviors are not always symptoms of underlying mental health disorders can impact the tendency to seek pharmacological interventions. Although the goal is to train all current and newly licensed resource parents on the RPC curriculum, there is an

insufficient number of facilitators statewide to develop a training plan or timeline for completion. Until there is statewide facilitator capacity, the training will not be required. In the meantime, to build enthusiasm around the program, the Children's Division is currently motivating resource parents' voluntary participation through active promotion and peer endorsement.

Informed Consent Policy

Children's Division completed a revision of the agency's informed consent policy, which went into effect September 1, 2018. Historically, resource parents had been authorized to provide consent for a child's behavioral health services and treatment, including psychiatric treatment and psychotropic medications. The revised policy now requires non-pharmaceutical interventions to be attempted first before initiating psychotropic medications. Additionally, the mental health professional involved in these interventions must make a recommendation for the child to be assessed for psychotropic medication before Children's Division arranges such psychiatric assessment. The child's case manager can provide consent for a psychotropic medication prescription, though resource parents can still consent to dosage increases or decreases. Policy now requires that informed consent be provided for a specific psychotropic medication and may not be used to imply informed consent for other medications as sometimes has been the case in congregate care settings.

The Center for Excellence and ProAct Advantage

Missouri Department of Social Services has a contract with the University of Missouri Health, School of Medicine, Department of Psychiatry for the purchase of the Center for Excellence in CHILD Well-being. The Center became operational in December 2018 and serves in an oversight capacity for ongoing monitoring and consultation, including telehealth, to Department case managers and supervisors regarding behavioral health needs and issues of children in out-of-home care. A primary function of the Center is coordinating oversight for the appropriate use and monitoring of psychotropic medications prescribed to children in foster care.

In this role, the Center is working closely with Care Management Technologies: A Relias Learning Company with whom the Department is contracted for the use of the *ProAct Advantage* tool. Based on Medicaid claims data, *ProAct* provides a myriad of data by population or individual, including best practice "red flags," gaps in care for chronic diseases, and integrated health profiles. The *ProAct* portal has been used primarily in the monitoring and oversight of psychotropic medications. The Center monitors quality indicators for best practices and alerts staff of children/youth hitting benchmarks falling outside of best practice. Guidance and next steps are offered to staff, as well as the opportunity to staff cases with the Center's clinicians. Staff and youth over age 18 are encouraged to make a referral to the Center for clinical consultation when there are questions around informed consent, a child's medication regimen, appropriate diagnoses, or other case/treatment planning needs.

Children's Division is examining prescribing practices in the state's residential treatment programs. Initiated January 2019, this initiative for monitoring and oversight is facilitated by the Center for Excellence. The Center provides the programs' Chief Executive Officers (CEOs) reports of their in-house or contracted psychiatrists' prescribing practices for children in state custody. The CEO is alerted when their psychiatrists' prescribing practice triggers behavioral pharmacy measures, or quality indicators (QI), falling outside best practice guidelines. Baseline data or initial impressions are not yet available while some changes are being made to the process, the data file structure, and the reporting requirements.

Consulting with and Involving Physicians or Other Appropriate Medical or Non-Medical Professionals in Assessing the Health and Well-Being of Children and in Determining Appropriate Medical Treatment

A multidisciplinary approach, collaborating with medical and non-medical professionals to assess the health and well-being of children and in determining appropriate treatments is critical to the child welfare system. The Children's Division relies heavily on partnerships with experts in the physical and behavioral health care fields to develop and support strategies for improving a child's access to quality health care.

Health Care Oversight and Coordination Committee

The Health Care Oversight and Coordination Committee (HCCC) meets quarterly and is comprised of medical and non-medical professionals, as well as state agency representatives. Membership includes the Children's Division, MO HealthNet Division (state Medicaid agency), Division of Youth Services, Department of Health and Senior Services, Department of Mental Health, Office of State Court Administrators, private foster care case management providers, pediatricians, child advocacy centers, residential program providers, foster parents, and foster youth. Meeting agendas include emerging practices or policies on which committee input is requested, review of HCY assessment data, discussion around access to quality medical and behavioral health care for children, identifying strategies for improved continuity of care and care coordination.

The Center for Excellence

As described above, the Department contracted with the University of Missouri Health for the establishment of the Center for Excellence in CHILD Well-Being. The Center became operational with Phase One, including behavioral health oversight and consultation, in December 2018. The Center's capacity to provide oversight and consultation for physical health is included in Phase Two of implementation, which is expected to be completed by the end of 2019. Currently on staff with the Center is a child/adolescent psychiatrist, a licensed psychologist, a pediatrician, a pediatric nurse, and several nurse case managers. The Center is instrumental in providing quality clinical consultation to staff to support quality health care for children in out-of-home care. Staff can contact the Center for consultations around psychotropic medications, treatment planning, informed consent questions, case management quandaries, and to request the Center clinicians conduct peer-to-peer consultations with providers around these issues.

Procedures and Protocols Established to Ensure Children are not Inappropriately Diagnosed (FFPSA)

Children/youth in CD custody are evaluated by qualified medical and behavioral health clinicians using age-appropriate, evidence-based, and validated assessment tools. Any resulting diagnoses are reviewed by the case manager and family support team and also reported to the court of jurisdiction to ascertain whether the diagnosis is agreed upon by those entities and supported by evidence. The diagnoses may help inform treatment plans, and they are one component of many sources of information considered to determine the level of support the youth's placement provider will need to meet the youth's needs. Should a case manager question a youth's diagnosis as it seems incongruent with symptoms observed by the family, resource parents, case manager, or other individuals closely involved with the youth, a consultation shall be initiated with The Center for Excellence. The Center, staffed with a child and adolescent psychiatrist and a psychologist, among others, will review the evaluation/diagnosis and, if in disagreement with the evaluation's findings, render a recommendation for next steps. Policy requires children to be placed in the least restrictive setting necessary to meet their individual needs. Youth referred for residential treatment typically have higher-level treatment needs and, following a screening and approval process, are determined would most benefit from a short-term residential program to achieve safety, therapeutic, and permanency goals. If neither the evaluator nor subsequent consultation with The Center recommends residential treatment, placement in a family home setting shall be made.

Health Care Transition Planning for Youth Aging Out of Foster Care

The goal of transition planning is to identify and arrange for anticipated service needs for older youth who will soon be exiting foster care. Youth who have a comprehensive plan are better equipped to transition successfully from foster care to self-sufficiency. It is imperative for staff, youth, and other Family Support Team members to discuss transition planning well in advance of the youth's impending exit so a well-informed and practical transition plan can be developed.

To prepare youth for their exit from the foster care system, the Children's Service Worker meets with the youth 90 days prior to release from custody to develop a personalized transition plan. Youth are educated on the importance of designating another individual to make health care treatment decisions on their behalf if they become unable to participate

in such decisions and the youth does not have or does not want a relative who would otherwise be authorized under law to make those decisions. This can be done by a health care power of attorney, health care proxy, or other similar document recognized by state law and youth should be educated as to how to execute such a document if the youth wants to do so. Policy and procedures exist for assisting youth in need of services transitioning from alternative care to adult guardianship or conservatorship or supported living through another agency such as Department of Mental Health (DMH) or Department of Health and Senior Services (DHSS).

Each youth is provided an “exit packet” prior to exiting from care. The exit packet must contain information regarding: eligibility for extended MO HealthNet coverage, durable power of attorney for health care and health care directive, services available through Chafee Aftercare, the Education and Training Voucher (ETV) program, National Youth in Transition Database activities, request to re-enter foster care, and additional resources germane to the youth’s geographic area such as services for disabilities, childcare, and public assistance programs.

On August 28, 2013, state statute extended medical coverage for former foster youth to age 26. The statute includes youth who were in foster care under the responsibility of the state of Missouri at the age of eighteen, or at any time during the thirty-day period preceding their eighteenth birthday. Recently added to the exit packet for youth under the age of twenty-one is a brochure on re-entry. Effective August 28, 2013, youth who exited care after the age of 18, but are not yet 21 years old, may elect to return to care under Missouri Senate Bill 205. The brochure outlines information on eligibility, the process for requesting re-entry, services available to youth re-entering care, and general expectations for transition planning. County offices were instructed to display the brochure in commonplace locations throughout the community to promote awareness.