YOUTH AGING OUT SURVEY
ISSUE: MEDICAL HEALTH

What strategies are in place in your state to help youth understand their medical needs?

Alaska
If a youth comes into state custody, we make sure that they receive a medical evaluation and that any recommendations from the EPSDT screening are dealt with. It is usually the expectation that the physician and the foster parent would work together to ensure that the youth knows what issues exist and how to deal with them.

Arizona
Caregivers, case managers and other supportive adults work together with each youth to ensure they understand their individual medical needs and understand the importance of preventive medical care. Case managers address specific medical needs within the individualized case planning process and case management supervision. Youth are referred to applicable rehabilitative service offices or other special services as needed. Contract life skills trainers also work with youth to understand and plan for medical/health needs as they transition to adulthood.

CMDP has nurses and a Medical Director on staff accessible to field staff for any questions and concerns pertaining to specific diagnosis and/or conditions. CPS Case Managers are made aware that these resources are available to them. Additionally, targeted training and education directed toward the older youth population is also accomplished through the Annual Youth Education Conference, which is an interactive forum to discuss various medical issues.

CMDP's case management/care coordination functions provide added support by assisting members with health risk factors or special care needs. In addition to the member's PCP, case management is available to help members use medical, social or community resources effectively with the aim of gaining self-management of their condition and optimizing medical and cost effectiveness. Case management service components include:

- Developing an individualized care planning that focuses on achieving member wellness
- Identifying and implementing effective interventions, which are based on the risk factors and conditions involved and are aimed at supporting the member's compliance with medical care and services
- Working collaboratively with members' health care professionals and providers, care givers, member's custodial agency and other entities (e.g., CRS, social service agencies) involved in delivering care to the member
- Working closely with other CMDP staff (utilization review, prior authorization or EPSDT nurses) to coordinate services for members with special needs
- Coordinating care for defined conditions/diseases to attain optimal clinical and quality of life outcomes.
- Providing education, support and monitoring for the member, member's care giver and others involved in the care
- Encouraging members (in collaboration with the member's care giver) to self manage their condition and sustain behaviors that may improve the member's quality of life.
- Monitoring the member's care and outcomes, documenting and tracking member information. Plans of care are modified as necessary in order to address any issues/needs and ensure effectiveness of the interventions.

An example of direct youth education is the Family Planning information included in new member packets for members age 12 and above. Youth are informed about a broad range of medically approved and accepted family planning methods so that they can make an informed, confidential decision, free from coercion or pressure. This information includes, but is not limited to:

- A completed description of available covered family planning services
- Information on how to request/obtain these services and that assistance is available

Recognizing the importance of education, the CMDP Maternal Health Coordinator (MHC) maintains a list of applicable resources and coordinates with case managers (legal guardians) and foster caregivers in efforts to provide appropriate resources and educational information regarding family planning and contraceptive counseling. Case managers receive the Family Planning Services form for youth age 12 and older. The MHC is available to offer assistance regarding family planning services, pregnancy related services and coordination of benefits.

Colorado
Child and Family Services Review emphasize well-being outcomes. Ansel-Case Life Skills Assessment includes assessment and learning plan information. In placement settings, youth receive information on their medications and health care.

Connecticut
The Bureau of Adolescent Services mandates that each youth 14+ be involved with our approved Life Skills Program. One of the components of this program is health issues. In terms of furthering those initial efforts we enhance our youth's knowledge by providing direct nursing support 5 to 8 hours a week in both the PASS group homes and the SWETP transitional programs to help youth understand their medical needs. In our IL Programs we have case managers work with youth on these issues.

Delaware
IL contract providers conduct workshops, guest speakers are invited to speak on health issues, and dangers of high risk behaviors, i.e. alcohol and illegal substance use are addressed.

Indiana
Wards have to have annual physicals, eye exams, and dental exams. If there are any special needs then we advocate for the child and the care giver to attend classes to educate them. Often times these sessions are offered by the doctors' offices or at one of the numerous children's hospitals in the state.

Iowa
Point of information: The Iowa Chapter of a national disability advocacy group known as Family Voices operates as one of the agencies under the umbrella of Ask Resource agency. Iowa has programs that help youth with disabilities understand their own needs.

Iowa COMPASS is Iowa's *free*, statewide information and referral service for people with disabilities, their families, service providers, and other members of the community. They maintain information on over 5,500 local, state, and national agencies and programs.

The Bureau of Disability Prevention helps communities promote healthful living and reduce the amount and/or severity of disability-related secondary conditions. The bureau provides public awareness messages about health issues such as arthritis, cardiovascular risk reduction and diabetes; assists in developing policies that encourage and support healthy behaviors and promotes behavior change programs designed to improve health. The bureau also staffs a violence prevention program.

The bureau is also concerned with reducing the amount and/or severity of disability-related secondary conditions, i.e., depression, pressure sores, etc. Bureau staff are working to provide people with disabilities information about health insurance, sponsor workshops on healthy living and assist providers with accessible medical care. Administrative support is provided to the Iowa Advisory Council on Brain Injuries.

Maine
Caseworkers and caregivers work collaboratively with the medical community to communicate medical conditions and needs to the youth in developmentally appropriate language.

Minnesota
For youth in care there, out of home placement plan and the independent living plan address health care needs of youth.

Mississippi
Every youth in placed in care is assigned a case worker or a county of service worker. All youth must have the opportunity to participate in independent living preparations, without regard to the youth's permanent plan. The County of Responsibility Social Worker must complete an Individual Service Plan (ISP) on all youth in care. This is discussed with the youth and assists in helping the youth understand their own medical needs. Each youth is assessed based on their personal and medical needs, and the youth also complete an Ansell-Casey Life Skill assessment. The results are processed with the youth.

Missouri
Youth participate in family support team meetings in which their medical needs are discussed and meet with their case managers.

Nebraska
Below is a portion of our Independent Living Guidebook that directs case managers on how to work with youth preparing for independent living.

All youth age 16 through 18, regardless of permanency objective, will have a Preparation for Independent Living Plan for supporting themselves as an adult. This plan shall include the youth's goals for employment, education, financial support, housing, a support system and transportation arrangements. Acquisition of Necessary Life Skills; the youth will have necessary life skills in the following areas:

- Locating and maintaining housing;
- Home management (food preparation, cooking, cleaning and laundry);
- Shopping and effectiveness as a consumer;
- Use of community systems and services;
- **Health care (personal care, family planning, medical assistance);**

The youth will have an enhanced self-identity by understanding her/his own past and having the documents necessary for self-sufficiency as an adult. Options to provide services include:

- Use of a life story book to understand past experiences and strengths and to improve the youth's sense of control over her/his life;
- Obtaining of necessary documents such as:
  1. Social Security card;
  2. Birth certificate;
  3. Driver's license, or learner's permit, if appropriate;
  4. School records and diploma or high school equivalency certificate;
  5. **Medical records, including immunization record, medical history;**
  6. Other documents necessary in the transition to independent living.

An assessment is done at age 18 for all youth in residing in group homes or Agency Supported Foster Care homes that includes the following questions. If the youth answers no to any of the questions and there is a need expressed or observed, the provider is expected to assist the youth in meeting the need

- Do you have an official copy of your birth certificate?
- Do you have a Driver's License or ID card from the state?
- **Do you know how to get your medical records if you need them?**
- Do you know how to get your school records if you need them?
- Did you participate in developing a plan for your transition from foster care?
- Do you have a written plan for your transition from foster care?
- Do you feel safe where you live?
- Do you have at least one adult in the community, other than your caseworker you can go to for guidance and support?
- Do you know where you will live after you leave foster care?
- Do you cook some of your own meals where you live?
- **Do you know where to call if you need medical care?**
- **Do you know where to call if you need dental care?**
- **Do you know why you would take prescribed medications?**
- Do you have any kind of bank account?
- Do you save money on a regular basis?
- **Do you have Medicaid of other health insurance?**
- **Do you have Medicaid or other insurance that pays for part of or all of your prescription drugs?**
- Do you do any volunteer work?
- Do you know about the education and training voucher program?
- Are you employed either full-time or part-time?
- Are you going to school or getting vocational training full or part time?
- Do you belong to any foster youth or alumni association?

The assessment also asks them if they would like the contact information of the Foster Care Alumni of America.

New York
OCFS is in the fourth year of a health care coordination pilot project. Each of the 8 pilot agencies has identified specialized staff to provide health care coordination. These staff are separate and distinct from caseworkers, and whose responsibility is to coordinate the health care needs of children/youth in foster care. Responsibilities include facilitating a comprehensive evaluation at the time of placement into foster care, expediting referrals, developing health care treatment plans for the child/youth, helping a youth in foster care know his/her own medical needs and training biological parents, where appropriate, and foster parents to be able to coordinate the child's health care. An evaluation of the project has indicated positive results in the 8 agencies. The plan is to institutionalize this strategy for all children in foster care and to support the approach through the reimbursement process provided by a Medicaid per diem rate.

Service Plan Reviews, Treatment Team Meetings and the discharge planning process are other strategies in place to help youth understand their own medical needs. A discharge protocol is completed 90 days prior to a youth's discharge to *another planned living arrangement with a permanency resource* (formerly known as Independent Living) and updated at the time of trial discharge and again at final discharge. Ensuring that a youth has private health insurance coverage or Medicaid that will support the successful

return to home and support access to needed medical care after discharge is one of the areas that caseworkers address with youth as part of the discharge planning process.

NYS has recently submitted and anticipates the implementation of a new Medicaid Home and Community Based Waiver for children in foster care. This new waiver called Bridges to Health provides an intensive health care integration approach for foster care youth with serious emotional disturbances, developmental disabilities and medical fragility. Services are initiated while a child is in placement and will follow the children/youth upon discharge from foster care. Through this program enrolled children and youth will be eligible to receive a variety of comprehensive, community-based support services targeted to each child's specific needs that will complement, not duplicate, services provided to these children through other programs. Additionally, youth in foster care are currently eligible for the NYS Office of Mental Health (OMH) Medicaid Home and Community Based Waiver for children with serious emotional disturbance, which is available in every county in New York and in New York City. Both programs provide the ability for children to remain in a least restrictive setting, receive education and support services, and obtain the necessary health care based on their individual needs.

The Permanency Hearing Report provides information related to a youth's health and mental health needs to assist the court in planning appropriately for the youth.

New York State's SACWIS system, known as CONNECTIONS, includes a health care summary module. This information must be shared with foster youth with a discharge planning goal of another *planned living arrangement with a permanency resource*.

North Carolina

In keeping with program goals, LINKS social workers are expected to assure that youth learn self care, including preventive health care, avoidance of behaviors that can create or exacerbate medical problems, understanding the purpose of any medical or psychiatric treatment and the impact of stopping psychotropic or medical drug treatments, etc. The actual training may be done by the therapist, health department personnel, foster parent or group home provider, the social worker, or others who have a relationship with the child.

North Dakota

Youth are included in their child and family team meetings, which occur on at least a quarterly basis. Our Residential Facilities, Foster Parents, Custodians, Case managers, and IL Coordinators assist youth on an individual basis with understanding their medical needs.

Ohio

Caseworkers are central to this process; generating the awareness of Medicaid and the resources available to the youth. Pamphlets are prepared by ODJFS that explain rights and responsibilities for youth about to age out of care. There is a consumer guide – to help consumer's understand their health coverage, in addition to a question and answer booklet for consumers.

Tennessee

Information is provided to youth upon their majority exit regarding the need for preventative health care and insurance. A booklet published by the Department of Health aimed at Teen/youth health issue is also provided. Newsletters from the TennCare (Medicaid)) managed care company on teen health are also made available.

Virginia
Youth are strongly encouraged to participate in service planning inclusive of their medical needs. Local department Independent Living (IL) programs offer preventive health and information to youth through workshops and information seminars.

Washington
Youth are included in case planning. Their medical information is shared with them while they are in placement and then given to them when they exit care.

Independent Living Program can assist in evaluating what the youth will need in order to be successful upon exiting care and provide this assistance until age 21.

SSI claims are processed as the youth turn 17.5 in order to have their eligibility reviewed under the adult disability criteria so that they may take their SSI eligibility (including medical) with them as they exit care. Claims that are denied are often pursued through redetermination and Administrative Law Judge (ALJ) hearing level even after youth are no longer in care provided youth are available and open to assistance.

CA regions coordinate with DDD regions to assist in transitioning youth to the adult DDD program.

<u>What strategies does your state use to inform youth about accessing medical services and resources?</u>

Alaska
Prior to leaving state custody, the youth and those working with them develop an exit plan that identifies where the youth would go to obtain medical services. In Alaska, youth are able to obtain under 21 Medicaid if they meet the financial requirements. Over 60% of the youth in state custody are Alaska Natives. Alaska Natives are eligible for care from the native health care system.

Arizona
The state Medicaid program, Arizona Health Care Cost-Containment System (AHCCCS) provides health care services through the state health plan, Comprehensive Medical and Dental Program (CMDP). CMDP provides a significant amount of information to youth and caregivers through a variety of mailings. CMDP staff also maintain a member services line to assist youth, caregivers and others who have questions about available services, health care provider networks, etc.

The CMDP medical directory and other staff have also provided information to youth and case managers through presentations at annual conferences.

Per the Arizona's Medicaid Agency, the Comprehensive Medical and Dental Program (CMDP) is required to mail out member newsletters on a quarterly basis. These are sent to the custodial agencies, legal guardians, and youths. These newsletters contain various articles on preventative care and the Health Plan contact/resource information to access individual medical needs. Additionally, the CMDP website is available to assist youth with navigating the Health Plan system and answering medical questions.

CMDP also has nurses and a Medical Director on staff who is accessible to field staff for any questions and concerns pertaining to specific diagnosis and/or conditions. CPS Case Managers/custodial agencies, who are assigned to each child/youth, are made aware that these resources are available to them. The CPS Case Managers are available to assist each child/youth with any medical and/or behavioral needs and questions that may arise.

Colorado
Part of Independent Living Planning
Part of Chafee independent living services planning
State passed Senate Bill 002; Authorizes Medicaid for youth emancipating from care ages 18-21 years

Connecticut
We offer life skills training on medical issues as an overview for all of our youth but again enhance the youth specific skills with nursing, social work and case management staff.

With all our youth we have formal conferences yearly on adolescent planning starting at age 14 with medical needs/issues/information as a component of the conference.

Delaware
IL contract providers conduct workshops and seminar; providers identify community resources that can help assist youth in addressing medical needs. Youth are able to apply for financial and medical services via internet through the Department of Health and Social Services.

Indiana
The majority of wards are placed on Medicaid so serves are easily accessible. Older youth are educated about additional medical coverage that is available to them once wardship is terminated. The state also holds transition meetings so youth know where to go in their community to obtain services and assistance.

Iowa
Youth who are eligible for Aftercare services via their involvement with Iowa's state paid foster care system can receive voluntary services including one-on-one assistance from a self-sufficiency advocate. This advocate will teach the young person about self care, access to health care coverage, and has been known to accompany the young person to doctor visits, when necessary.

Implementation of Iowa legislation passed in FY 03 expands the requirements for the transitioning of youth from foster care into adulthood. Iowa law now mandates that the case permanency plan include a written transition plan of services for youth, 16 years and older, in foster care in addition to the establishment of local transition committees to address the transition needs of youth.

Maine
Our Life Skills Educators and Children's Services caseworkers continue to assist youth age 18 with making sure that they reapply for MaineCare medical coverage as adults. An information memo was sent to all DHHS district staff with respect to the process for reapplying for MaineCare and continued Medicaid eligibility. Most of our older youth in care continued in care at age 18 qualify for continued medical coverage under the federally established poverty income guidelines used by MaineCare. The few young adults who have not qualified for continued coverage were working full time and did not qualify for coverage based on income guidelines.

Minnesota
Resources can be found at either the Project C-3 and/or the MinnesotaHelp websites for youth in transition.

http://www.c3online.org/aboutUs.htm

http://www.minnesotahelp.info/public/default.aspx?se=youth

Also, local social service and public health agencies can provide community resources.

Mississippi
All youth are offered the opportunity to participate with Independent Living activities. These activities are an important venue for youth to become more informed of all medical services and resources available to them. The county workers, Independent Living specialists, and resource families have partnered to ensure information is shared about what is available to youth. Youth participate in weekend activities and conferences throughout the year, which is used to announce services and resources to youth.

Missouri
Missouri is in the process of developing an aftercare packet for older youth with this information in it. Youth can also learn this information from participation in independent living classes as well as through their case managers.

Nebraska
Approximately 3 months prior to the youth exiting the system, the Protection and Safety Worker should conduct a Team Meeting with all of the people important to the youth, including both formal and informal supports. The youth should help to identify who they want at the meeting. The Independent Living Plan for the youth should be discussed and at a minimum include living arrangements, employment, educational plan (including the Former Ward Program and Educational and Training Vouchers Program), budget, transportation, health care, social life, recreation, acquisition of important documents and formal and informal support system. Roles and responsibilities should be assigned for any tasks needing to be accomplished prior to the transition to independent living.

Our Preparation for Adult Living Services and Transitional Living Programs are required by contract to achieve the following outcomes for youth age 16 and older referred to them:

- Youth have sufficient resources to meet their daily living needs
- Youth have a stable place to live
- Youth attain academic or vocational educational goals
- Youth have a sense of being connected
- Youth avoid illegal activities
- Youth postpone parenthood
- Youth have access to physical and mental health services
- Youth have a sense of well being

New York
Foster youth over the age of 14 are required to receive life skills training in the area of accessing community resources, including health and mental health services. The Department of Health has required notices for persons who become eligible for Medicaid and at the time of termination of services. In NYS we support continuous coverage for all youth who are transitioned from foster care into their community. These letters advise youth on how and where to access Medicaid to ensure their continued eligibility for Medicaid and access to health care.

It is also the responsibility of the case managers, case planners and nurses in any foster care agency to discuss with youth all issues related to their health care, to inform them of the services available, to discuss appointments and to arrange for transportation to the appointments. It is also their responsibility to provide opportunities for the youth to discuss any concerns that they may have regarding their own health issues.

Discharge planning addresses providing for identified medical/mental health needs upon discharge. The 90 day notice required for youth being discharged from foster care to *another planned living arrangement with a permanency resource* or for youth aging out of foster care must identify any needed service

providers. This would include the identification of and arrangements with heath care providers after discharge when there are health/mental health issues.

OCFS in partnership with Youth in Progress, the statewide foster care youth advisory group, developed a Handbook Youth in Foster Care and a plan for distribution and the ongoing distribution of the handbook The handbook includes a section on foster youth rights and responsibilities related to health care.

North Carolina
LINKS social workers are expected to involve youth in learning about medical services in their geographic area and to help aging out youth to apply for Medicaid benefits for which they may be eligible. LINKS Services continue until the youth is 21. Youth are informed of new and existing resources as a part of services provided by the agency.

North Dakota
The custodians/Private agencies/Facilities/Foster Parents/Case managers all assist youth with accessing medical resources and services while in care. The Regional Independent Living Coordinators assist youth until the age of 21, or 23rd birthday if the youth is participating in the ETV program, with accessing medical resources.

Ohio
Youth approaching age 16 that are going to age out of the foster care system are introduced to Independent Living courses. The courses are designed to create a knowledge and self-reliance for the youth which include services such as daily living skills, assistance in obtaining a high school diploma or general equivalency diploma, assistance in preparation for post secondary education and training, and the development of positive relationships and support systems. The children services agencies are to provide youth aging out a copy of their health and education records free of charge as well.

Tennessee
Youth are encouraged to sign up for insurance on their employment, and/or extend their TennCare (eligibility) benefits as they qualify. Outreach on eligibility is provided through the interdependent living staff

Virginia
We have IL trainings, workshops, group meetings and individual meetings.

Washington
Community organizations such as the Mockingbird Society work in partnership with the department to educate youth on available services.
Independent Living program offers information regarding availability of medical services.
Foster parent website
Foster parent newsletter
Foster care website

<u>What partnerships and initiatives has your state developed to ensure that youth maintain necessary medications, proper health insurance, and access to local physicians?</u>

Alaska
While in state custody, the review system and the exit plan both monitor the medical needs of youth. Once out of state custody, it is much more difficult to monitor. For youth with mental health issues, plans are made to transfer the youth to adult services and if appropriate, obtain a guardian.

Arizona
Arizona chose to exercise the Medicaid option available under the Chafee Foster Care Independence Program when it became available in 2000. Medicaid eligible youth who will reach the age of majority while in care are pre-enrolled into an AHCCCS plan the month in which they turn 18. The state worked cooperatively with internal and external partners to develop an expedited referral and eligibility determination process to ensure youth would maintain enrollment in a health plan regardless of whether or not they chose to remain in services past age 18. Due to state plan requirements, youth must participate in an annual re-determination process; however, there are no income restrictions to this category of coverage.

While the child/youth is our care, members are encouraged to select a primary care provider (PCP) from CMDP's Preferred Provider Network. CMDP also has a list of providers known as the Comprehensive Assessment Medical Providers. This group consists of providers whose special skills and interests are in the areas of: child abuse and neglect, children with special healthcare needs, adolescent medicine, and developmental pediatrics. The PCP is responsible for coordinating the member's overall healthcare, including referring the member to a specialist as needed. Primary care providers make medically necessary referrals for specialty treatments and services to meet each member's needs. The Medical Services Unit, in coordination with the Provider Services Unit, is also available to assist the member, caregiver; PCP and custodial agency representative in locating a specialist to ensure the member's medical needs are being addressed appropriately.

Through provider education and outreach activities, CMDP ensures all providers in its network are aware of the special health care needs of children in foster care, including their need for EPSDT well-child screenings and assistance in receiving these services in a timely manner. CMDP disseminates updates and other pertinent information to providers as necessary through on-site visits, Provider Newsletters, the Provider Manual and special letters / reminder postcards, as is deemed appropriate.

The Comprehensive Medical and Dental Program, in accordance with the Medicaid guidelines, is required to identify and facilitate coordination of care of all members transitioning to another Medicaid Health Plan. A CMDP Care Coordinator completes an Enrollment Transition Information (ETI) form within 30 days of the member's termination date. The ETI form includes: medical conditions, chronic illnesses, specialty medications, recent approved prior authorizations i.e., treatments, durable medical equipment, or services, names of physicians/specialists, recent hospitalizations. The ETI is utilized to communicate to the new Medicaid Health Plan the necessary information to ensure continuity of care. CMDP has two Medical Care Coordinators who monitor this process and provide individualized assistance for the more complex cases.

To ensure that each child either "aging out of the system" or returning home does not experience a lapse in medical coverage, the State of Arizona has a transitional medical coverage for up to 60 days with another Medicaid Health Plan.

Colorado
Links; Guide to Mental Health Services in Colorado
Youth Net; Website of Resources/Links for Youth With Disabilities
State passed Senate Bill 002 which authorizes Medicaid for youth emancipating from care ages 18-21

Connecticut
The Department has nurses working with all social workers to address/direct/access medical services for our youth. It also has a Medical Assistance Unit to help find/approve appropriate medical services for our youth.

Delaware
IL providers assist youth in applying for health insurance and benefits. They help youth locate a primary physician through their health insurance program and make referrals for Psychiatric care. IL providers make referrals to agencies that provide assistance with medication compliance.

Indiana
Indiana provides Medicaid to youth that age out of care. This is a comprehensive Medicaid plan that covers medication, mental health needs and preventative care. This Medicaid is available up to age 21.

Iowa
The Iowa Department of Public Health has an ongoing initiative that trains primary care health providers on how to provide a "Medical Home" to youth and families.

Maine
It should be noted that there seems to be more of an issue of medical coverage for those youth who have reached the age of 21 and lose their medical coverage at that point, particularly for those youth who are still working to complete their college degree. We recently met with our DHHS Deputy Commissioner who will be bringing together a group of key people to strategize about ways we might be able to offer some form of extended medical coverage for former youth in care after age 21 at least until the point that a youth graduates from their college program. An ad hoc committee convened to identify how health insurance can be extended to provide coverage for young adults who are still in college when their extended care is terminated at age 21.

With the merging of the Department of Human Services and Department of Behavioral and Developmental Services two years ago, management teams from the former two departments have been meeting to ensure that older youth who have been in the state child welfare system have a timely and smooth transition to adult mental health and mental retardation services. A protocol for use of different types of professional evaluations was drafted by staff from DHHS Child & Family Services and staff from Children's Behavioral Health Services and is nearly completed as of February 2007. The Chafee Program Manager worked with CFS and CBHS staff to draft the protocol and guidelines.

Mississippi
There are various partnerships established to ensure youth maintain necessary medications, proper health insurance, and access to local physicians. Youth in care are covered for proper health insurance through Medicaid. Youth who leave MDHS custody on or after their 18th birthday, but who have not reached their 21st birthday are eligible for Medicaid, through the month they turn 21, without regard to income or resources, for Medicaid coverage. Foster children who are receiving Medicaid or Health benefits under other categories such as SSI, TANF, Economic Assistance, CHIPS, and Regional Medicaid will not be in the category for automatic continuous Medicaid Coverage up to age 21. Those individual programs will have to determine eligibility for continued coverage.

Missouri
Routine medical/dental care services are available through the Healthy Children and Youth (HCY) Program, also known as Early Periodic Screening, Diagnosis and Treatment (EPDST). Children entering out-of-home care need initial medical examinations, as well as regular medical examinations throughout their out-of-home care placement. Plan with out-of-home care providers and other appropriate team members ensure that all children in out-of-home care receive education on sexual development, appropriate to their age, life experiences, and living conditions. This information should include information on sexuality and sexually transmitted infections. Children in out-of-home care are eligible for MM/DSP (Medicaid, Title XIX). As a result, they are also eligible for HCY services. Bureau for

Children with Special Health Care Needs (BCSHCN) provides some medical services not covered by Medicaid. To make a referral for a child, the Children's Service Worker should make sure that the needed medical services are not covered by Medicaid. When it has been determined that the needed medical services are not covered by Medicaid, the Children's Services Worker may make a referral to the appropriate regional bureau office. The Department of Mental Health (DMH) provides mental health services to children who are determined to be eligible for the services. Children in Out-of-home care and who are in need of mental health services may be referred to the appropriate DMH facility determined to meet the needs of the child. Three separate DMH divisions deal with the following: Comprehensive psychiatric services; Mental retardation and developmental disabilities; and alcohol and drug abuse. Children in out-of-home care are eligible for private psychiatric hospital care. These facilities provide services including medical treatment, psychiatric/psychological counseling and testing, nursing care, educational services, social work services, recreation services and occupational therapy. The Children's Services Worker should contact the hospital directly to arrange for the child's admission. Cost for the child's care is paid by Medicaid for a number of days as prescribed by the Professional Activity Study (PAS). Payment for days beyond the PAS days may be paid with Area Office approval. The psychiatric facility should request prior approval of the extension through the Division of Medical Services (DMS) for extended Medicaid payment of the service. If DMS denies, the psychiatric facility should submit the request for payment to the County Office. Such a request is forwarded through normal supervisory channels to the Program Development System Unit (PDSU). Children in out-of-home care who require special care directly attributable to a medical/physical/developmental disability may be eligible to receive medical foster care.

Nebraska

We have partnerships with contracted providers to work with each youth age 16 and older referred to them to educate the youth on how to obtain access to medical services and health insurance.

New York

NYS is a state supervised, locally administered state. Most partnerships that support specific access are either contracted by or supported at the county or agency level. At the state level, in 2005, NYS amended its Medicaid State Plan to provide categorical eligibility for all children in foster care. This assures that all youth in foster care have access to health care. In addition we developed a manual for all foster care providers and staff entitled, "Working Together, Health Services for Children in Foster Care which provides comprehensive guidance on the NYS requirements and best practice guidance on the provision of health care to children in foster care. This manual was done in partnership with two other organizations that were simultaneously developing new guidance and standards for health care. The first was the Department of Health EPSDT manual and the second was the American Academy of Pediatrics, Region II Manual on Health Care (for providers). All 3 of these guidance manuals were developed to complement one another and provide a consistent message on the delivery of health services to children. In NYS we also have a Medicaid per diem method of reimbursement which provides a more flexible approach to accessing health services and supports more individualized treatment for youth The OCFS Home and Community Based Medicaid Waiver Program will provide individualized services that are more responsive to the unique health needs of children in foster care and not generally available in the NY Medicaid State Plan of services.

Child Advocacy Centers provide a coordinated approach to CPS investigations where a child/youth has experienced physical or sexual abuse or other health trauma. Within the centers a child receives comprehensive health examinations, trauma reduction intervention and a coordinated approach to the interviewing that is associated with CPS investigation of sexual or severe physical abuse cases.

North Carolina
The Division of Social Services has proposed legislation that would extend Medicaid benefits to all youth who age out of care until they are 21. This legislation is currently under consideration.

LINKS services and access to resources continue until the youth's 21st birthday. Aftercare services frequently help youth to get connected to needed health and dental care. If the youth is not eligible for Medicaid or other insurance, LINKS (Chafee) Funds may be used to defray the cost of medical care.

North Dakota
The child and family team assists the youth until they age out of care. The IL Coordinators work with the youth until their 21st birthday, or 23rd birthday if the youth is participating in the ETV Program.

Ohio
O.H.I.O. Youth Advisory Board is advocating for Medicaid & Financial support for youth who age out of care until 23. While this initiative is in OHP's budget, HB 119, the Senate included statutory authority for the department to amend the state Medicaid plan to implement beginning 1/1/08 a federal option under which an individual under age 21 qualifies for Medicaid if the individual (1) was in foster care on their 18th birthday, (2) received IV-E FCM or IL services prior to turning 18, and (3) meets all other eligibility requirements.

Tennessee
Youth who remain eligible for TennCare (Medicaid) remain in the same managed care company for a minimum of 6 months after exiting care so that they have access to the same provider network. Youth who are disabled with MR or MH have a case manager through the adult MR or MH programs. Mental health case management would remain available for adult MH youth, and an independent coordinator is assigned for youth who are MR and part of the MR waiver (Medicaid). Interdependent living case managers are trained on access and advocacy to TennCare (Medicaid) services, and may contact the Well Being division of our department if a barrier to services for a youth is identified. The Well Being health advocate representative will file an appeal as needed on accessing any TennCare (Medicaid) service.

Virginia
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Washington
DSHS created an "Interim Voucher" in partnership with the pharmacy board which guarantees payment for services even if the youth does not have their medical coupon. The voucher is now a tool used with medical providers as well as pharmacies. Legislation in 2007 extended Medicaid benefits for youth aging out of care until they turn 21.

<u>What practices does your state utilize to acquire and maintain complete medical records for youth?</u>

Alaska
Records can be obtained electronically.
Public Health maintains records of immunizations are kept.
Medical records are a part of the case file.

Arizona
State policy was revised in the last year to specify what health/medical records are to be provided to a youth prior to their exit from foster care. Current policy directs the assigned case manager to:

- Provide the young adult with adequate family history, including necessary family medical history (i.e. history of diabetes, cancer, and high blood pressure or other illnesses or conditions which may impact the youth's future health status), photos, letters or other family history available in the case record.

- Provide all youth with a copy of their health and education record within 30 days of their 18th birthday. The youth's health record shall include but is not limited to notes and records of medical and dental professionals regarding:
  - immunizations,
  - hospitalizations,
  - specific illness or diagnosis,
  - surgeries,
  - medications,
  - consultations with specialists,
  - contact information for the current primary care physician and dentist, and
  - mental health records including psychiatric and psychological evaluations and provider reports.

- Redact mental health records (i.e. psychological and psychiatric evaluations, provider reports) to protect (i.e. source information from a child protective services hotline report) sensitive information about family members or others referenced in the evaluations and reports.
- If the CPS Specialist believes a portion of the information may be harmful to the young adult, therapeutic intervention/assistance will be requested as appropriate to meet each young adult's needs.

The Primary Care Provider maintains the complete paper medical record for each youth and CMDP has access to these records. CMDP tracks a youth's medical history by two entities, CMDP electronic claims history via the QMACS system and the Arizona State Immunization Information System (ASIIS). From the CMDP electronic claims history, CMDP is able to identify date of service, diagnosis, physician, and type of service. CMDP Care Coordinators can provide this information to CPS Specialist and youths upon request. ASIIS is an immunization registry that serves as a statewide tool for reporting and capturing data. CMDP Medical Services staff, in addition to public and private health professionals, has the ability to report and monitor immunization records in ASIIS. These records are obtained by CMDP to ensure that the youth is properly immunized and to prevent re-administration of immunizations.

Arizona has a unique model, in that the Child Welfare System and the Medicaid Health Plan (CMDP) are all part of the same system, i.e., Department of Economic Security (DES). What this means is that we are able to share data electronically between the Child Welfare System and the Health Plan as part of daily business operations through both divisions of the same agency and not as an extra database that needs to be supported and funded.

Arizona's Child Welfare IT system (CHILDS) used for the Child Protective Service (CPS) case management notes and tracking and the CMDP IT system (QMACS) have data elements that download nightly from one system to the other. The CMDP system is set up to download to the CPS system all data from medical bills that were paid for that day in regular CMDP business operations for: immunizations (specific to the immunization), well child visits (EPSDT), dental visits, and certain key diagnoses, etc.

This data is then cross-walked and "translated" into lay terms and put in specific fields into the CPS case management IT system, so it is readily available (& understandable) for the legal guardian's (CPS case managers) review. In a similar fashion, data elements, which the CMDP Health Plan needs, are captured from the CPS IT system & downloaded into the Health Plan system.

In addition, all well-child information from EPSDT's is entered into the CMDP EPSDT database, which again makes data queries easier. All immunization data from paid claims or from EPSDT visits is entered into the Arizona Statewide Immunization Information System (ASIIS), so that any Arizona healthcare provider can access the child's current immunization status when the youth leaves foster care or ages out of the child welfare system.

CMDP uses the statewide mandatory ASIIS System to query for past immunizations on children as they enter out-of-home placement. In addition, we also use the Az. Dept. of Health Services information re; results of newborn screening as important information that we gather on children entering out-of-home placement. This information is forwarded to the CPS case manager (legal guardian), so they have a starting point for healthcare. CMDP also assists the CPS staff in identifying the previous PCP, prior to entering out-of-home care, should the parent not be cooperative.

The Centers for Medicare/Medicaid Services, Health & Human Services have awarded $103M in system transformation grants to 14 States Medicaid Agencies, which included Arizona. Arizona is in the implementation phase for e-Health Connection Readiness statewide and will use this federal funding to further system transformation and development of electronic health information (EHR) and health information exchange (HIE) capability. It is the Governor's intention that the all the State Medicaid Health Plans (including CMDP) will lead this initiative as all of our data is already in electronic and standardized formats which are downloaded to the Arizona State Medicaid Agency (AHCCCS) on a regular basis. This data is required for health plan operations and CMS oversight and reimbursement of TXIX and TXXI funds to AHCCCS (and then the health plans).

CMDP and Arizona's Child Welfare System have been asked to present our Information Technology model and data sharing models in a 2007 conference in Washington, DC, as other states have found it quite interesting. The conference is the **10th National Child Welfare Data and Technology Conference: Making IT Work: Linking Data with Practice and Outcomes** sponsored by the National Resource Center for Child Welfare Data and Technology (NRC-CWDT). Their mission is to assist State, local and tribal child welfare agencies and the courts in improving outcomes for children and families through the use of information technology.

Colorado
Youth may request these documents from the county that provided them child welfare services or contact the provider directly to obtain health information

NOTE: This area is a topic that is being discussed in several venues and the challenges with a technological solution such as an e-passport are being explored amidst the challenges and concerns of HIPPA, Identity Theft, Privacy Concerns, etc.

Connecticut
Medical Records are components of a youth’s records.

Delaware
When a youth is seen by medical and/or mental health professionals, copies of the reports are obtained and filed in the youth’s case record. Medical records follow the youth if and when there is a change in placement. The Department’s policy requires that a Transfer Instruction Sheet (TIS) with accurate and

current information regarding the youth's school, medication, and other medical, emotional, or behavioral information be developed. The TIS should accompany the youth when entering contracted residential placement or foster car or moving from one residential program to another. Youth must request their complete medical records from their physician or case manager when they exit care. Medical information is also kept in the Department's Family and Child Tracking System (FACTS).

Indiana

Indiana has contracted with providers to assist youth aging out of care in obtaining their medical records.

Iowa

As Federal law requires states to provide "early and periodic screening, diagnosis, and treatment" (EPSDT) services to Medicaid-eligible children (under age 21), Iowa calls the program "Care for Kids" and recommends that children receive health, vision, and hearing screenings at the following ages:

- 1 month, 2 months, 4 months, and 6 months
- 9 months, 12 months, 15 months, 18 months, and 24 months
- 3 years, 4 years, 5 years, and 6 years
- 8 years, 10 years, 12 years, 14 years, 16 years, 18 years, and 20 years.
- (Note: Foster care physical examinations are required more frequently than EPSDT screenings, except for children under age two.)

Maine

Child and family health histories and documentation of preventive, acute, and chronic health care for children in the care or custody of the Department are gathered and maintained in order to assist in the assessment of the child's health status, to provide continuity of health care, to avoid duplication of services, and to carry out the Department's duties and responsibilities toward children in its custody.

A family health history is to be obtained for each of the child's biological parents. This is to be sought along with the child's health history if possible, and if needed for diagnosis or treatment of the child, to the degree possible it will be sought immediately. Otherwise this is to be obtained upon request of the child's physician, within 30 days of a final protection order or the initial administrative case review, whichever occurs first.

A portable health record provides a health history to foster parents, residential child care facilities, and physicians; enhances communication among physicians, foster parents, and caseworkers; provides information in an emergency situation; provides documentation of health services received; and provides a permanent health record for the child, the child's physicians, and the child's parents or guardian following the child's discharge from the Department's care or custody.

Minnesota

For all youth in foster care, the local social service agency is required to maintain important health information including physicians, dentists, medications, history and medical needs of the youth in the out-of-home placement plan within the Minnesota SACWIS. The plan must be created in collaboration with the youth and updated on a routine basis. The youth signs the plan and receives a copy of the plan. Vaccination history is required information for all students in Minnesota public schools, so that history is also maintained in the youth's school record. Youth have a right to their own child welfare record. If the youth was not placed under the guardianship of the Department of Human Services Commissioner, the youth's record is available until the 26th birthday. Youths under guardianship of the Commissioner have access to their own records as long as they live.

Mississippi

The County of Responsibility and/or the County of Service Worker is responsible for carrying out the plan that is established in the youth's ISP. The County of responsibility has the ultimate responsibility to

ensure accurate and up-to-date information is submitted in the Mississippi Automated Child Welfare Information System.(MACWIS). This is the computer data that is kept automated. The worker assigned to the case also keeps any hard copy records that will be needed for future case responsibility. All of the workers have been trained and informed of the confidentiality importance for their case files.

Missouri
The Children's Service Worker ensures that initial medical information is obtained from the parent/physician and given to the foster parent within 72 hours, if possible, but no later than 30 days following placement. The Children's Service Worker establishes and maintains a medical record (separate and distinct section in the file or separate record) on each child in care. The record includes copies of the initial medical examination report and ALL existing medical records on the child, including both current and past medical information. Also included in the medical record is a copy of the log of illnesses, medications and the amount given, visits to physician/therapist and the purpose of the visit. The initial health examination shall occur within 24 hours of the child coming into care. If possible, this initial examination should be a complete HCY screening (physical, eye, hearing, dental examinations). If only a partial screening (physical examination) can be completed within 24 hours, eye, hearing and dental examinations shall occur within the first 30 days the child is in care. Ongoing medical care should be obtained in accordance to the HCY examination/immunization schedule. All information about the child's medical care while in out-of-home care shall be shared with the parent/caregiver on an ongoing basis. A copy of the complete medical history should be furnished to the parent/guardian. The Children's Service Worker shall ensure that all children receive education on sexual development, appropriate to their age, life experiences, and living conditions. This education should include information on birth control and venereal diseases. Birth control should be made available to all children that are sexually active. All efforts to comply with this policy must be clearly documented in the record. Parents should be involved in the decision, and if in disagreement, the worker should get court approval.

Nebraska
All medical records are kept in the youths file and are maintained at our local service offices until such time as the case is closed. Upon closure of a case, the file is maintained in a vault and a system is maintained to request information from closed records. Former state wards can request information from their files regarding education, medical and mental health services, social history etc. Our N-FOCUS System documents the names of the primary care physician, psychologist/psychiatrist, dentist and therapist and dates of the last contact, visit or exam. We are also able to document medical characteristics of youth in this system.

New York
Many agencies in NYS have begun to use on line medical records maintained in each agency. In addition, NYS has developed a health services component within the electronic NYS Case Management system that supports the documentation of all Initial Assessments, ongoing chronic health conditions, hospitalizations, medication, etc. Medical information is also accessed directly through release of information signed by a parent allowing access to children's comprehensive medical records. NYS has recently developed an Immunization Registry that supports access to up to date information for all children and their immunization records.

North Carolina
N.C.G.S.§ 7B-2901 states, "The Director of the Department of Social Services shall maintain a record of the cases of juveniles under protective custody by the Department or under placement by the court, which shall include family background information; reports of social, medical, psychiatric, or psychological information concerning a juvenile or the juvenile's family…"

Children in foster care placements have physical examinations scheduled within seven (7) days of the date of their placement. The agency must ensure that the child receives all needed evaluations, medical care and psychological treatment services needed through referral to other agencies and providers.

Counties must ensure that the child shall be provided with his/her health and education records at the time the child exits care at age 18. The supervising agency will need to document that these records have been given to the child at the times indicated.

Counties shall include the most recent health and education records for the child in the case plan. Case plans must include documentation of child-specific recruitment efforts made by the county to facilitate in-state and interstate placements. These case plan requirements were effective October 1, 2006. This provision includes all children in the foster care system for whom recruitment efforts are necessary to achieve permanence.

North Dakota
North Dakota's foster care system has included "providing medical records to youth" as part of our discharge planning checklist.

Ohio
Based on the Ohio Administrative Code, Healthcheck is to be provided to children and teens. Healthchek is provided through Ohio's Medicaid program. The basic services are: Screening Services; Vision Services, Dental Services, Hearing Services, Behavioral Health and other Rehabilitative Services and other Medically Necessary Services. This program follows youth up to their 21st birthday.

Tennessee
While not the official record keeper for any child's medical records because our department is not a health care provider, we track all health services provided to youth in our care. Services and appeals tracking coordinators are made available in all regional programs of our state to track services for youth. When service needs are identified through an EPSDT screening appointment or a medical or dental appointment, the noted service is tracked in the child welfare tracking system as an identified service for which an appointment is needed. Once the appointment is obtained, it is tracked until the service is accessed. A "health confirmation and follow up form" is completed by the provider. A medical summary of both the primary health issues and services can be printed from the child welfare tracking system.

Virginia
EPSDT

Washington
The Child Health and Education Tracking (CHET) program gathers available health and education information which is then kept in the child's record. New information is incorporated as it is received by the social worker. Upon exiting care, this information is provided to the youth.

Youth with complex health needs are assigned to a Foster Care Public Health Nurse (FCPHN). The FCPHN gathers and reviews all available health information and writes a Comprehensive Health Report (CHR). The CHR is shared with the youth, their caregivers and medical providers as appropriate.

Medicaid billing data for health, dental and mental health services is accessible to social workers and other necessary CA staff. It is not a complete medical history but can provide some information regarding past treatments, medications and issues the youth may have had.

Name and contact information of state individual regarding health and medical issues

Alaska
Jay Butler
Director of Public Health
Location:
350 Main Street, Room 508
Juneau, Alaska 99801
Mailing Address:
P.O. Box 110610
Juneau, AK 99811-0610
(907) 465-3092
DPH@health.state.ak.us

Arizona
DES/DCYF Independent Living Coordinator
Beverlee Kroll
(480) 545-1901 ext. 15886
bkroll@azdes.gov

Susan M. Stephens, M.D., CMDP Medical Director
SusanStephens@azdes.gov
Mary Ferrero, R.N., CMDP Medical Services Manager
MFerrero@azdes.gov

Colorado
Bob Coulson, Adolescent Services
(303) 866-4706

Connecticut
Frank Martin
(860) 550-6592

Delaware
Truman Bolden, Independent Living Program Manager;
(302) 633-2638
truman.bolden@state.de.us

Indiana
Cassandra Porter
(317) 234-4211

Iowa
Iowa Medicaid Enterprise

Maine
Virginia Marriner
Acting Director of Policy & Practice
Office of Child & Family Services
Department of Health & Human Services
221 State Street

Augusta, ME 04333
(207) 287-5060

Minnesota
Steve Vonderharr
(651) 431-4666
steve.vonderharr@state.mn.us

Mississippi
For the Department of Human Services/ Division of Family and Children's Services, Independent Living Program please contact:
Sergio A. Trejo, Program Administrator, Sr.
Mississippi DHS-Division of Family & Children's Services
State Independent Living Coordinator
750 North State Street
Jackson, MS 39202
(601) 359-4983
strejo@mdhs.state.ms.us

Missouri
Tricia L. Phillips or Sally A. Gaines
Missouri Children's Division
PO Box 88
Jefferson City, MO 65103-0088
(573) 526-5408 or (573)522-6279

Nebraska
Mark Mitchell
Health and Human Services
P.O. Box 95044
Lincoln Nebraska 68509
(401) 471-9211
mark.mitchell@hhss.ne.gov

New York
Dianne Ewashko
Office of Strategic Planning and Policy Analysis
(518) 473-7373

North Carolina
Thomas Smith, Foster Care Consultant, DSS
Thomas.Smith@ncmail.net

Leah Devlin, Director, Department of Health
Leah.Devlin@ncmail.net

Ohio
Office for Children and Families Help Desk
50 W. Town Street
Columbus, Ohio 43215
Help-desk-ocf@odjfs.state.oh.us

(866) 886-3537

Tennessee
Audrey Corder, Executive Director of Well Being
8th floor, 436 6th Avenue North, Nashville, TN 37243
(615) 741-9206

Washington
Michelle Bogart
Foster Care Health Issues Program Manager
Email: bogm300@dshs.wa.gov
(360) 902-8006