NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Division of Social Services

Health Care
Oversight and Coordination Plan
2025-2029

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1 Introduction

Federal law [Social Security Act, Section 422(b)(15)(A)] requires states to develop a plan for the ongoing oversight and coordination of health care services for children in foster care. In response, the North Carolina Department of Health and Human Services (NC DHHS), Division of Social Services (NC DSS) has developed this Healthcare Oversight and Coordination Plan (HOCP) for state fiscal years 2025-2029, in concert with the NC Department of Health Benefits (NC Medicaid) and in consultation with the pediatricians and other experts in health care, child welfare experts, and recipients of child welfare services serving on the NC DSS Child Well-Being Design Team. North Carolina's overarching goal for its 2025-2029 HOCP is to meet the physical, social-emotional, mental, and behavioral health needs of children, youth, and young adults served by its foster care program. The following objectives are detailed in Section 4, along with the interventions, benchmarks, and timeframes for achieving those objectives:

Objective 1: Uphold policies, practices, and healthcare-related services that pertain to children in North Carolina's child welfare system;

Objective 2: Strengthen health programming for transition age youth; and

Objective 3: Ensure prescribing of psychotropic medication to children in foster care is safe and appropriate.

2 Lessons Learned and Current Efforts

North Carolina's HOCP for the period July 2020 — June 2024 was managed by NC DSS, in partnership with NC Medicaid and with contributions from county child welfare agencies, juvenile justice, community-based health care providers, managed care entities, transition age youth, and other stakeholders with lived experiences. For the past five years, NC DSS and partners have worked together to: (a) enforce existing child welfare practice health services policies, (b) analyze health-related data specific to children in foster care, and (c) further coordination and communication among providers to meet the physical and mental health care needs of children in foster care. Many favorable outcomes have resulted from the state's 2020-2024 plan and subsequently serve as the foundation for its 2025-2029 HOCP to promote cohesion, continuity, and comprehensiveness. The lessons learned from implementing the plan for 2020-2024 have also informed the development of this current HOCP.

2.1 Lessons from the 2020-2024 HOCP Period

Lesson 1 – Target 1: Streamlining healthcare was made more difficult by competing pandemics. The child welfare system did not anticipate the increase in demand for physical and mental health services during the COVID and the opioid crises. Improvements made during the 2020-2024 HOCP period (e.g., definitions added to child welfare policy manual and the roll-out of new Medicaid tracks) were met with an influx of youth in crisis with no appropriate level of care readily available. The increase in the number of children living with mental illnesses under extreme duress (before, during, and after COVID) worsened conditions for children and youth in foster care. NC counties were bombarded during 2020-2024 by children with acute mental health needs being boarded in hospitals and/or county DSS offices, with nowhere to go. This made it hard for NC DSS to streamline healthcare for children and youth in foster care.

It was also reported that residential care providers, because of reduced staffing levels post-COVID, could not keep up with the demands of the foster care population. Although the number of children coming into care has not changed much in recent years, the number of licensed foster homes in North Carolina plunged 23% from 2021 to 2022, according to federal data. That left the state with approximately 5,400 licensed homes for more than 10,200 children in care. As a result, an overreliance on institutional care may have ensued, particularly for youth with high acuity needs with fewer placement options. These children often ended up cycling in and out of county DSS offices, juvenile detention centers, higher levels of care than necessary, emergency departments, and/or psychiatric hospitals. The situation was exacerbated by a lack of providers trained to conduct trauma-informed assessments and/or providers who were unavailable to complete comprehensive clinical assessments in time. These challenges made it difficult for NC DSS to measure progress and steady course and hindered the state's ability to achieve Target 1 of its 2020-2024 HOCP, which sought to streamline the healthcare of children and youth in foster care across the child welfare workforce and the medical community.

Lesson 2 – Target 2 – The timing of healthcare reform (i.e., during COVID) impacted the healthcare planning for older and transition age foster youth (TAY). North Carolina's Medicaid Transformation took place after the approval of the 2020-2024 HOCP. The undertaking was extensive, requiring many months for preparation and implementation. Massive communication and a series of training webinars for child welfare audiences and Medicaid providers ensued. In addition, the start-ups of Medicaid Expansion, Tailored Plans, and NC's Foster Care Specialty Plan (which encompassed the rollout of the Healthcare Passport for the TAY group) were announced during 2020-2024 but were postponed several times, affecting projected eligibility for some children and families.

NC DSS was also confronted with unforeseen worker and provider shortages at a time when new resources were required to successfully transform Medicaid. Several counties continue to experience staff shortages across child welfare and provider pools (e.g., dental providers are available in only half of NC's counties). The effects were evident with older foster youth, who reported they were not seeing their workers and providers face-to-face and were therefore not as engaged in their transition case plans as they were prior to COVID. Youth were exiting foster care with no intent or means to maintain contact with workers. Agencies reported delays with setting up medical appointments for the TAY population, due to the difficulty in obtaining medical records from pediatricians when requested by the custodial agency or foster parent after DSS custody was terminated.

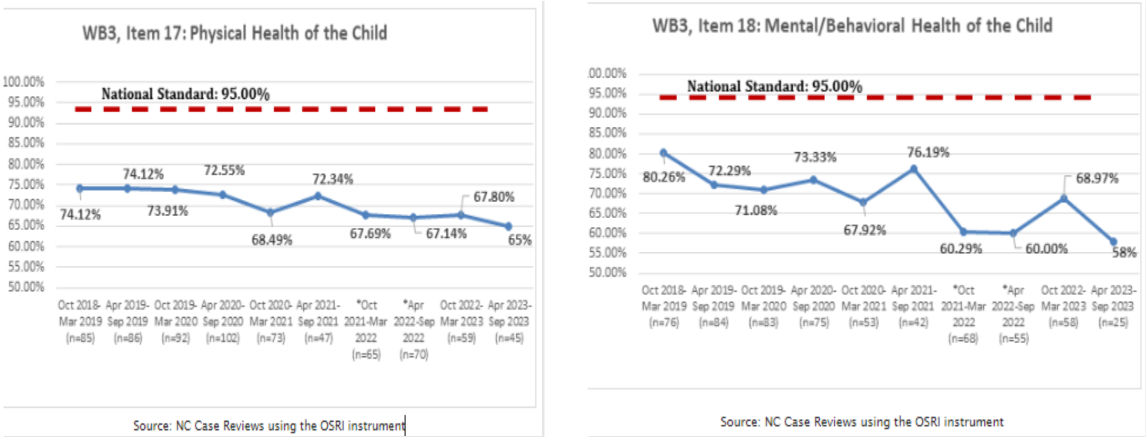
These issues resulted in lack of communication and delays in delivering healthcare to former foster youth seeking normalcy while transitioning to adulthood. Workers were not always able to implement recommended services for youth due to reduced provider capacity. In the best of cases, when former foster youth managed to maintain connection with their foster caregivers and medical home, and/or when granted access to their childhood medical records, they were often unable to secure follow-up appointments on time due to waitlists and overcrowded calendars of providers accepting Medicaid. These challenges made it difficult to strengthen healthcare programming for the TAY population and thus interfered with North Carolina's achievement of Target 2 of the 2020-2024 HOCP, as well as Target 3, which concerned monitoring of psychotropic medications at the local level.

Lesson 3 - Target 3 - Oversight of medication in children and youth in foster care required child welfare and Medicaid to first align policies, practices, and procedures before putting forth efforts to track statewide performance. Communication between Medicaid and child welfare information systems was a challenge for NC's state-supervised, county-administered foster care system, particularly in real time and in the absence of a statewide data system. Lack of a statewide tracking system hindered North Carolina's ability to measure and report on statewide performance during 2020-2024 and/or to make adequate comparisons based on common variables (e.g., county size). These challenges created the perfect lessons learned for NC DSS and NC Medicaid: that is, to better coordinate internally beyond silos and system barriers and to put in place several joint, data usage agreements as part of the 2020-2024 HOCP. During the 2025-2029 HOCP, the lack of a statewide data system will be addressed through the development and deployment of NC Child Welfare Information System (CWIS) modules and interfaces. In the interim, dashboards that derive data from Medicaid billing codes are being utilized by NC DHHS to monitor medication use, diagnostic patterns, and the overutilization of psychotropic medications on children in foster care.

2.2 Current Efforts to Strengthen Healthcare Oversight and Coordination

Going forward, to strengthen oversight and coordination of the health of children and youth in foster care, North Carolina seeks to improve its performance on the federal Child and Family Services Review items 17 (physical health of the child) and 18 (mental/behavioral health of the child). As the figure below shows, although it fluctuated over the period of the 2020–2024 HOCP, performance on both these measures has declined overall.

Figure 1. Performance on Items 17 and 18, Oct. 2018–Sept. 2023



Source: NC Case Reviews using the OSRI instrument

Source: NC Case Reviews using the OSRI instrument

Several factors are behind this decline. Critically, lack of a statewide tracking system interferes with North Carolina's ability to track performance and intervene when improvement is needed. Other challenges affecting performance include staffing shortages, lack of providers in some areas/counties (e.g., dental providers exist in only half the state's counties), and higher acuity needs of children in care. Other barriers, as reported by local agencies, are inability to secure timely follow-up appointments and difficulty obtaining children's health records from providers. The factors behind the decline in performance have also impeded progress on 2020–2024 HOCP Target 1 (streamline healthcare of children in foster care), Target 2 (strengthen programming for transition age youth), and Target 3 (strengthen protocols for monitoring psychotropic medications at the local level). Current efforts to strengthen healthcare oversight and coordination across North Carolina are detailed below.

Strengthening Child Welfare and Medicaid Policies. A review of the existing child welfare practice health services manual, as part of the 2020–2024 HOCP efforts, uncovered a few policy statements that were missing critical elements (e.g., due dates for completing the initial screening, timelines for processing Medicaid eligibility forms). To support timely access and delivery of services to children in care and to address their physical and mental health needs, NC DSS and NC Medicaid worked together throughout calendar year 2023 to enact timelines for the completion of the DSS-5120 (Determination of Foster Care Assistance Benefits and or Medical Assistance Only form) as part of the Foster Care Affinity Project under CMS. As of November 1, 2023, the DSS-5120 must be completed within seven business days of the child or youth entering foster care. For NC DSS, this change is reflected in the Permanency Planning Policy Manual. It is purposed for county child welfare agencies to work with county Medicaid eligibility staff to ensure the timely determination of eligibility and subsequent enrollment/reenrollment of benefits to avoid breaks in healthcare coverage. The child's initial health screening was also clarified in policy to be required to be completed within seven days of placement.

Incorporating a Trauma-Informed Lens Statewide (Tools, Templates, and Training). NC DSS is working to update its child welfare policies to require the use of two trauma-screening tools in all counties during 2025-2029: the Trauma Screening Tool (0-5) (DSS-6195a) and Trauma Screening Tool (6-21) (DSS-6195B). The statewide use of trauma screening tools is contingent upon NC DSS receiving approval from the Children's Bureau on the new FFPSA plan. In addition, by the close of SFY 2025-26, NC DSS will roll out the Foster Care Specific Trauma-Informed Assessment template for use across the entire state by all mental health/behavioral health providers involved with children in the foster care system, to include all health plans. The trauma screening tools and statewide trauma-informed assessment template will be incorporated in Trauma-Informed Leadership Training that is slated to continue statewide.

Collaborating with State Agencies and Local Providers to Combat the Behavioral Health Crisis in Child Welfare. In collaborative efforts amongst state and local provider agencies to combat the mental health/behavioral health crisis and to improve its ability to meet the needs of children, NC DHHS has invested in initiatives to address trauma experiences of children involved in child welfare, to prevent and/or minimize children's unnecessary stays in emergency room and local DSS offices, and to create specialized behavioral health treatment options in local communities for children at risk of placement and/or in need of a level of care higher than family foster care due to co-occurring, chronic healthcare condition and/or acute mental/behavioral treatment needs. Notable initiatives that were planned, rolled out, or in operation during SFY 2023-24 as part of Medicaid Transformation, Medicaid Expansion, and/or Special Legislative Budgeted Items include the following.:

- **Crisis Services** – Data shows children in foster care use mobile crisis services more frequently than children not in care. However, children in inappropriate crisis settings, such as boarding in emergency departments and/or in the county DSS offices, are a major concern in North Carolina. Children who are ready for discharge and/or step down, but who continue to be placed in psychiatric residential treatment facilities

(PRTF), psychiatric hospitals, out-of-state placements, and on Innovation Waiver waitlists indicate the need to create sustainable services and appropriate care settings across the state to address the needs of children in crisis.

- **Emergency Placement Funds (EPF) to Counties** – In February 2024 the legislature, through a pass-through allocation to NC DHHS, made special funds available to county DSS agencies straining to provide appropriate placements for children in their custody. The funds were specifically earmarked to improve placement viability for children with complex behavioral health needs. Allocations were made based on each county's percentage of the foster care census and purposed to minimize the occurrence of children having to stay in county DSS offices overnight while awaiting placement in Medicaid-funded treatment. EPF also aims to improve care for children with complex behavior needs by implementing practices shown to support better placement and stability of children (e.g., maintaining a crisis placement provider on retainer who meets the child's behavioral health needs until an appropriate treatment placement can be located).
- **Supporting the Rapid Response Team (RRT)** – This NC DHHS cross-divisional team meets daily to review referrals for children in DSS custody who are in hospitals or county DSS offices and are unable to access treatment at the medically recommended level of care. In SFY 2023-24, the RRT reviewed roughly 260 referrals of children from 70 counties. The team includes representatives from NC DSS and NC Medicaid, as well as from the Divisions of Child and Family Well-Being, Mental Health, Developmental Disabilities, and Substance Abuse Services, State Operated Health Care Facilities, and psychologist and psychiatrist consultants associated with NC Psychiatric Access Line (NC-PAL). The Division of Juvenile Justice and Delinquency Prevention and other state agencies are invited as needed. The RRT's roles and responsibilities include:
    - Reviewing completed referral and any other requested documentation to evaluate placement needs and to plan next steps.
    - Facilitating and convening a meeting of staff from Local Management Entities/Managed Care Organizations (LMEs/MCOs) and county DSS offices to coordinate a plan for treatment at the medically recommended level of care.
    - Working to remove barriers created by systemic issues, when possible, and to facilitate problem solving and challenging conversations among stakeholders.
    - Helping to identify potential alternative service options and/or the potential to wrap services together to meet the unique needs of children/youth.
    - Escalating referrals to the NC DHHS Executive Response Team when appropriate.

- Collecting, tracking, and reporting data collected through RRT referrals, meetings to inform policy, funding requests, and strategic priorities for NC DHHS.

Enhancing Statewide Data Systems. As mentioned above, to address the lack of a statewide tracking system, the state is developing and will deploy the CWIS. Linking the Medicaid administrative claims of children and their caregivers with case-level data from the child welfare system and combining state-specific datasets into a multi-state, deidentified dataset for secondary data analysis is a work in progress. In the interim, as detailed in Section 3.4, NC DHHS is using dashboards that derive data from Medicaid billing codes to monitor trends and patterns of health and mental health services furnished to children in foster care.

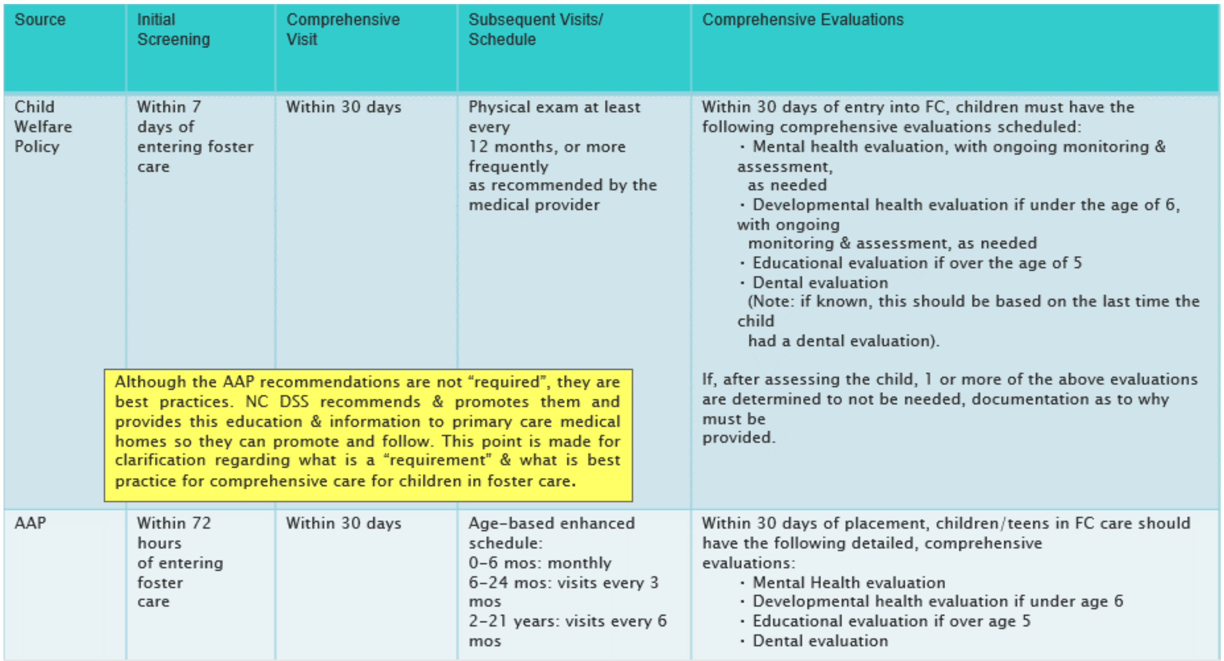
3 Required Elements

North Carolina requires physical and mental healthcare services be provided to children in foster care pursuant to federal and state mandates. NC DSS authority to oversee the healthcare of children in foster care is embedded in Administrative Code (Title 10A, Health and Human Services, Chapter 70, Children's Services), state child welfare policy, and state statute (N.C.G.S. § 7B). As required by the Social Security Act, this HOCP addresses the following items.

3.1 Initial and Follow-Up Health Screenings

When children enter foster care in North Carolina they must receive an initial health screening (including oral health when applicable), plus an emotional trauma screening that meets reasonable standards of medical practice. Each child in care for 30 days or more must also receive follow-up medical visits as warranted, as well as ongoing assessments, monitoring, and treatment to address their identified health needs. The table below lists the schedule for initial and follow-up screenings which address physical health, dental health, and mental health of children in foster care, as well as an enhanced schedule for screenings as recommended by the American Academy of Pediatrics.

Table 1. Required Health Screenings for Children in Foster Care



Source	Initial Screening	Comprehensive Visit	Subsequent Visits/ Schedule	Comprehensive Evaluations
Child Welfare Policy	Within 7 days of entering foster care	Within 30 days	Physical exam at least every 12 months, or more frequently as recommended by the medical provider	Within 30 days of entry into FC, children must have the following comprehensive evaluations scheduled: · Mental health evaluation, with ongoing monitoring & assessment, as needed · Developmental health evaluation if under the age of 6, with ongoing monitoring & assessment, as needed · Educational evaluation if over the age of 5 · Dental evaluation (Note: if known, this should be based on the last time the child had a dental evaluation). If, after assessing the child, 1 or more of the above evaluations are determined to not be needed, documentation as to why must be provided.
AAP	Within 72 hours of entering foster care	Within 30 days	Age-based enhanced schedule: 0-6 mos: monthly 6-24 mos: visits every 3 mos 2-21 years: visits every 6 mos	Within 30 days of placement, children/teens in FC care should have the following detailed, comprehensive evaluations: · Mental Health evaluation · Developmental health evaluation if under age 6 · Educational evaluation if over age 5 · Dental evaluation

Although the AAP recommendations are not “required”, they are best practices. NC DSS recommends & promotes them and provides this education & information to primary care medical homes so they can promote and follow. This point is made for clarification regarding what is a “requirement” & what is best practice for comprehensive care for children in foster care.

Source: NC Child Welfare Manual

As described in the above table, within 30 days of entry into foster care, children also must have the following comprehensive evaluations scheduled:

- A mental health evaluation, with ongoing monitoring and assessment as needed;
- A developmental health evaluation if under the age of 6, with ongoing monitoring and assessment as needed;
- An educational evaluation if over the age of 5; and
- A dental evaluation (NOTE: if known, this should be based on the last time the child had a dental evaluation).

Children and youth in foster care in North Carolina are considered children with special health care needs. As such, they should be seen by a healthcare provider early and often as needed.

3.2 Monitoring and Treating Children’s Health Needs

Prescribed screenings and medical visits must occur at the required intervals and all medical services (including dental services) must be documented in the child's record for monitoring and assurance using the relevant NC DSS forms, which include the following.

- *Health Summary Form – Initial Visit (DSS-5206)*. Completed within seven calendar days of the child’s entry into foster care. At the initial visit the medical provider examines the child for signs and symptoms of communicable disease, screens for chronic health conditions, inquires about prescribed and provided (on hand) medications, immunization records, current allergies, and if the foster child has any need for specialty care or additional services, such as home visiting. The medical provider signs the DSS-5206 and a copy is shared with the child's caregiver and filed in the child's record.

- *Health Summary Form – Comprehensive 30-Day Visit (DSS-5208)*. The comprehensive visit ensures continuity of health care services, which may include establishing a medical home for the child. It is also utilized to further delve into a child's history (which is appropriately shared with the child's medical team and caregivers as needed) and to assess for emotional trauma associated with the child's maltreatment and removal from the home. Information captured at this visit includes details about child's chronic health conditions (e.g., asthma, diabetes), surgeries or hospitalizations, emergency department overnight stays, past injuries, side effects of current medications, physical and visual impairments, other screening information, growth chart data, and the child's dental home and/or oral health. Mental health and disability information may be captured as well. The comprehensive visit also captures the planning and recommendations for follow-up treatment and/or intervention plans for current health conditions, including additional lab testing and/or evaluation needed.

3.3 Updating and Sharing Medical Information

North Carolina updates and appropriately shares the medical information of children in foster care using the tools and methods described below.

- *Health History Form (DSS-5207)*. This form is completed and shared with the child's medical provider (ideally their medical home/primary care physician) one week prior to the child's Comprehensive 30-Day Visit. The DSS-5207 captures valuable health history and background that may be difficult for medical home providers to obtain. This information provides insight into what is needed to address a child's trauma and how to develop the best treatment plan to address the child's physical, behavioral, and oral health needs. Information captured on the form includes family and birth history (including for siblings placed together), dental care history, any specialty care and/or behavioral health provider history, other health professional history such as occupational, physical, and/or therapy, and substance abuse history, if any. Some information on the DSS-5207 is obtained prior to the comprehensive visit through other sources (e.g., via provider's electronic health record portal or communication with birth parents). Screening results, discharge summaries, and relevant developmental information (e.g., the child's IEP) may be attached to the DSS-5207. A copy of the completed form, along with any updates, is shared with the child's medical and placement providers and filed in the child's record. Each child's DSS-5207 must be updated every 12 months and whenever medical circumstances change. This form is an effective tool for tracking how children's health needs are being monitored and treated, including emotional trauma associated with maltreatment and removal from home.

- *Health Summary Form – Comprehensive Scheduling Follow-Up Well Visits (DSS-5209)*. This form documents physical exams and is completed at least every 12 months, or more frequently if recommended by the child's medical home.

During monthly contacts, child welfare workers monitor factors that directly affect health, such as prescribed medications, medical and mental health appointments, and changes in affect. Workers also gather information on factors that indirectly impact health and well-being, such as relationships and changes that occur within the placement, contact with birth family members, educational needs, and extracurricular activities. To ensure consistency in visits, the Monthly Permanency Planning Contact Record (DSS-5295) is a required documentation tool. This form provides a framework to monitor changes and/or emerging needs identified during the child welfare worker's monthly visits with the child. In addition, child welfare workers regularly discuss the child's physical and mental health status with the parents, placement providers, the child (if age appropriate), and other applicable team members during quarterly permanency planning reviews to ensure the child does not have unmet or ongoing medical needs that require attention. During permanency planning reviews, the child's physical, dental, mental, and behavioral health are discussed. Any health information and concerns or needs (including medication concerns) is documented on the Permanency Planning Review Form (DSS-5241).

North Carolina is considering the creation of a healthcare passport for youth aging out of care, contingent upon the development of electronic health records for youth in foster care. This initiative is slated to be completed by the end of calendar year 2025 as part of the Child and Family Specialty Plan under NC Medicaid.

3.4 Ensuring Continuity of Health Care Services

NC DSS ensures coordination of care and continuity of health care services for foster youth by (1) working to establish a medical home for children in care, (2) managing foster children's health and mental health needs primarily through Local Medicaid Entities/Manage Care Organizations, and (3) using data usage agreements between NC DSS, NC Medicaid, and various university partners to identify data sets to understand and improve performance at the local, regional, and state level.

Use of the Medical Home Model – Collaborations with Healthcare Providers. North Carolina embraces the medical home model because this model enhances access to and coordination of specialty care, other health care (e.g., dental treatment) and educational services, in- and out-of-home care, family support, and other public/private community services important to the well-being of children in foster care. NC DSS collaborates with NC Medicaid, the state chapter of the American Academy of Pediatrics, primary care physicians, county DSS staff, and care management entities to promote the use of the medical home model for children in foster care. Using the Fostering Health North Carolina (FHNC) program and other means, North Carolina encourages the use of the medical model across the state through webinars and facilitates its implementation through a virtual health portal, child welfare policies, and training.

Tailored Care Management. To ensure continuity of health care services, in 2022 NC DHHS began a new track, Tailored Care Management (TCM), the result of the transformation of Medicaid in North Carolina. TCM for children and youth in foster care is primarily provided by LMEs/MCOs associated with the child’s Medicaid administrative county. Some foster children with severe behavioral health diagnoses and service needs are TCM-eligible. This includes some children with mental health, intellectual/ developmental disability, and substance use disorders. Children and youth who met these criteria were auto enrolled in TCM based on an algorithm. For children who do not meet TCM criteria, care management entities such as Care Management for At-Risk Children (CMARC) and Community Care of North Carolina (CCNC) will continue to serve the foster care population and spread the word to others about creative ways in which coordination with child welfare agencies across the state occurs. Since the rollout of TCM, NC Medicaid and NC DSS have and will continue to work jointly to provide training to CMARC, CCNC, LMEs/MCOs, child welfare agencies, and provider communities.

Data Points. North Carolina uses data usage agreements to help it understand and improve its performance related to the health of children in foster care. For example, NC DSS and NC Medicaid continue to track bi-directional data points. Trends identified through analysis are shared with counties, providers, and state agency partners to ensure the needs of children in care are met. The table below provides an example of data that has been extracted and shared for monitoring purposes.

Table 2. NC Children's Health-Related Data as of March 13, 2024

	NC Average	Children in Foster Care
PCP visit w/in 6-months of enrolling in Medicaid program	52.3%	86.4%
PCP visit w/in 12-months of enrolling in Medicaid program	65%	94.1%
PCP visit w/in 24-months of enrolling in Medicaid program	79.6%	97.4%
ADHD diagnosis (per 1000)	29.1	146.9
Adolescent depression screening (per 1000)	28.3	49.6
Autism screening (per 1000)	3.1	6.6
Pediatric dental screening (per 1000)	65.3	109
Psychosocial screening (per 1000)	37.2	57

NC DSS also uses Medicaid dashboards to track children in settings of concern. Children in emergency departments and county DSS office settings are tracked, as well as children in PRTFs and/or psychiatric hospitals deemed ready for discharge. Children on the Innovation waitlist (registry of unmet needs) who are receiving any Medicaid or state behavior health/IDD service are tracked as well. Dashboards are also utilized to follow up within seven days after in-patient discharge. This information is tracked by Medicaid and regularly shared with NC DSS.

In addition, in February 2024 NC DHHS launched Child Behavioral Health Dashboards. This public-facing tool brings together data from multiple sources and includes key metrics on behavioral health diagnoses relative to children and adolescents in care; this tool can be used to drill down to view race gaps, ethnicity, age, and gender disparities. Utilization metrics will serve to provide insights on the use of emergency departments, mobile crisis services, and PRTFs for children behavioral health care. Data from Child Behavior Health Dashboards will give NC DSS and Medicaid users the ability to better identify disparities and trends in child behavioral health across North Carolina and among individual populations groups, such as for children in DSS custody. By bringing together data from various systems, the dashboard will provide visibility into child behavioral health needs and allow for shared stakeholder accountability to identify and address opportunities for improvement.

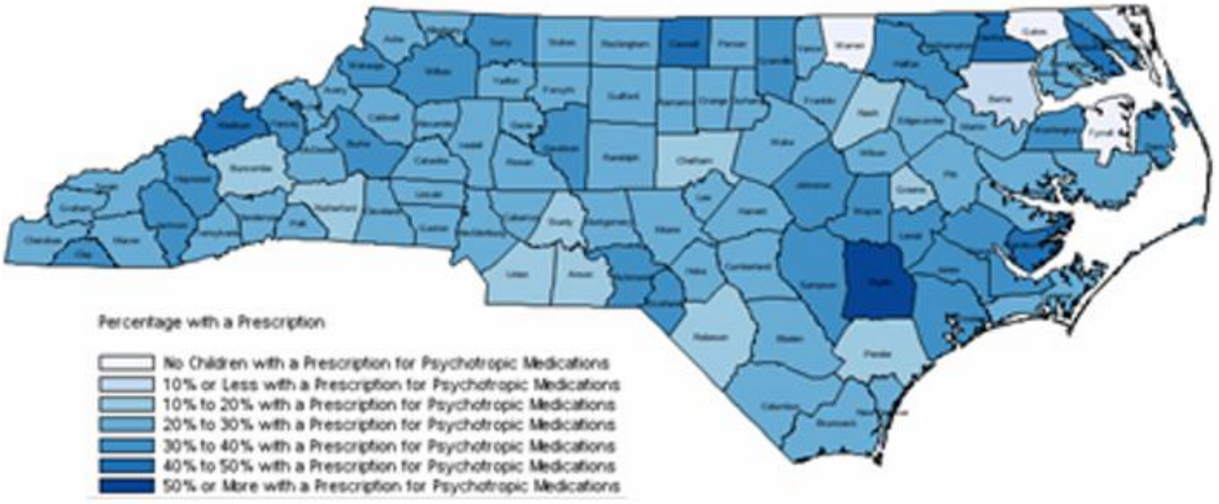
3.5 Oversight of Prescription Medications

North Carolina continues to monitor psychotropic medications prescribed to children in foster care to ensure they are used appropriately. Policy requires custodial county DSS agencies to monitor all psychotropic medications for side effects and, where indicated, to complete appropriate monitoring. County DSS agencies must obtain authorization for consent from the child's parent/caretaker for all prescribed psychotropic medications and include this authorization in the child's records. Form DSS-1812 (General Authorization for Treatment and Medication) instructs agencies to encourage parents to communicate with the provider who prescribed or recommended the medication to discuss the risks, benefits, and potential side effects. Parents' receipt of verbal and written information directly from the provider ensures information about the child's condition and recommended course of treatment is communicated accurately. Once consent has been given and the medication administered, agencies provide frequent status reports to parents/caretakers.

To build and sustain capacity for oversight of psychotropic medications, NC DSS also provides specialized training on the subject to county child welfare staff, including information about how to recognize patterns that may indicate concern (e.g., a child is prescribed too many psychotropic medications, too much medication in general, or at too young an age).

As part of its oversight, NC DSS routinely reviews data on prescriptions of psychotropic medication for children and youth in foster care. The figure below provides an example.

Figure 2. Percent of Children in Foster Care Prescribed One or More Psychotropic Medications, October 2023



Source: Medicaid Claims Data October 2023 provided by DHB NC Medicaid

As the figure shows, in North Carolina prescription of psychotropic medication to children in foster care is common. With exception to four counties (Camden, Gates, Tyrrell, and Warren), in most counties 20% to 30% of children and youth in care have been prescribed one or more such medications. One county reportedly has psychotropic medication prescribed for over half the children in its care, child welfare data from this county shows there are twenty-one children in foster care, of those, three are ages 0-3, eight are ages 6-12, and ten are aged 13-17. With the majority of children in foster care in this county between the ages of 6-17 there may be a number of reasons why the psychotropic medication rates are higher. To identify why this county is an outlier NC DSS will complete further analysis to determine if psychotropic medications are being prescribed appropriately for these children, this will include a closer analysis of the Medicaid claims data for each of the children and case reviews to ensure documentation supports the need for medication.

The fact that prescribing of these drugs varies considerably from county to county, by race, and by age is possibly cause for concern. For more on these variations, see the tables below.

NC DSS also works with university partners to capture and analyze medication utilization data relevant to the foster care population across the state. Results from one such effort are shown in the tables below. This information, drawn from a 14-month period spanning January 2022 to February 2023, was presented for discussion about root causes to the NC DSS Child Well-Being Design Team in October 2023 and again at a Joint Planning meeting in March 2024.

Table 3. Children in Foster Care Prescribed One or More Psychotropic Medication, by Race & Ethnicity • *Jan. 2022 – Feb. 2023*

Race/Ethnicity	Jan. 2022	Feb. 2023	Change
Black	26.53%	26.53%	-
American Indian Children	19.70%	17.94%	↓
Other	20.30%	21.04%	↑
White	25.43%	26.23%	↑
Non-Hispanic	25.38%	25.72%	↑
Hispanic Children	21.42%	22.94%	↑
All Children	25.03%	25.49%	↑
Total Number of NC Children in Foster Care	10,296	10,448	n/a

Table 4. Children in Foster Care Prescribed One or More Psychotropic Medication, by Age • *Jan. 2022 – Feb. 2023*

Age	Jan. 2022	Feb. 2023	Change
0 to 4	3.04%	3.43%	↑
5 to 9	25.84%	27.32%	↑
10 to 14	45.86%	43.45%	↓
15 to 17	43.10%	43.96%	↑
Total Number of NC Children in Foster Care	10,296	10,448	n/a

Table 5. Percent of Children in Foster Care Prescribed One or More Psychotropic Medication, by Drug Type • Jan. 2022 – Feb. 2023

Drug Type	Jan. 2022	Feb. 2023	Change
Amphetamine, Dextroamphetamine, or Mixed Amphetamine Salts Psychostimulants	5.33%	5.16%	↓
Anti-epileptic Drugs with Potential Use as Mood Stabilizers	4.51%	5.03%	↑
Antipsychotic Agent, First-Generation	0.39%	0.32%	↓
Antipsychotic Agent, Second-Generation	9.03%	8.54%	↓
Benzodiazepine Anxiolytics, Buspirone, and Other Benzodiazepines	0.83%	0.81%	↓
Clonidine, Guanfacine IR	6.43%	6.62%	↑
Guanfacine ER	6.63%	6.38%	↓
Hydroxyzine	4.01%	4.39%	↑
Lithium, Bi-Polar Disorder	0.52%	0.52%	-
Methylphenidate Derivative Combination	6.72%	7.21%	↑
Non-SSRI Antidepressant Agent, Second-Generation	4.34%	4.33%	↓
SNRI Antidepressant Agent, Second-Generation	0.41%	0.37%	↓
SSRI Antidepressant Agent	7.60%	7.91%	↑
Strattera and Selective Alpha-2 Receptor Agonist	1.38%	2.12%	↑
Tricyclic Antidepressant Agent	0.29%	0.34%	↑

Based on the data above, NC DSS notes children in foster care, especially adolescents, are significantly reliant on psychotropic medications, underscoring the prevalence of mental health challenges in this population. To minimize the overuse of psychotropic medication and misdiagnoses involving children in foster care, as part of the 2025–2029 HOCP NC DSS commits to:

1. Enforcing informed and shared decision–making (consent and assent) policies and methods for ongoing communication between the prescriber, the child, the child's caregivers, other healthcare providers, the child welfare worker, and other key community partners.
2. Working with NC–PAL to update and provide training, to reiterate protocols to child welfare agencies, primary care physicians (PCPs), pharmacists, mental health providers and caregivers about the need for medication oversight and to further

raise awareness about recent OIG investigations and the overuse of psychotropic medications.

3. Employing utilization maps and data from the recent study described above to engage the NC DSS Child Well-Being Design Team in ongoing dialogue about the gaps and need for improved systems to support the mental health of foster youth and to gain a comprehensive understanding into medication practices throughout the child welfare system.
4. Continuing to monitor documentation in case records pertaining to medication.
5. Completing a CQI series across regions on overuse of psychotropic medication in child welfare and the need for oversight and adherence to established protocols.

3.6 Working with Experts in the Health and Medical Treatment of Children in Foster Care

North Carolina actively consults with and involves physicians and 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. As part of this, NC DSS garners the expertise of the following.

Child Medical Evaluation Program (CMEP). The University of North Carolina's Department of Pediatrics oversees the NC Child Medical Evaluation Program on behalf of NC DSS. CMEP is a resource for North Carolina's child welfare agencies when assessing concerns for child maltreatment. A statewide network of qualified providers assists North Carolina child welfare by providing medical evaluations and treatment plans. North Carolina's Child/Family Evaluation Program (CFEP) is a component of the CMEP. CFEP provides forensically informed mental health evaluations for children and youth who are being actively investigated by child protective services as possible victims of abuse or neglect.

Commission on Children with Special Health Care Needs. This governor-appointed board regularly convenes to monitor and evaluate the availability and provision of health care services to special needs children in North Carolina, including services provided under the health insurance program for children. NC DSS actively attends commission meetings to learn and exchange information with attendees and advocate on behalf of the foster care population.

Infant and Early Childhood Mental Health Advisory Association (IECMH). Members of this association include North Carolina educators, healthcare professionals, government entities, and nonprofits involved in systems in care of young children, such as in education and foster care. IECMH focuses, in large, on the development of the capacity of a child to form close and secure relationships and to experience and express a full range of emotions. Through the association, NC DSS is privy to high impact training and has access to experienced healthcare experts. Like others who serve on the advisory committee, NC DSS advocates for the full continuum of services, supports, and policies necessary to promote healthy development and intervention and treatment of mental health disorders on behalf of foster children ages zero to five.

North Carolina Pediatric Society – Fostering Health NC. Fostering Health NC (FHNC) is a program under NC DSS that was managed via contract with NC Pediatric Society from 2020-2024. For the ensuing 2025-2029 HOCP, NC DSS will continue programming using the FHNC model to further improve the health and well-being of children and youth in foster care through integrated communications and coordination of care. Through FHNC, NC DSS will provide education and training on health and well-being matters specific to youth in foster care and bring key stakeholders together to problem solve and brainstorm (e.g., transition age youth, private agency providers with healthcare professionals).

North Carolina Psychiatry Access Line (NC-PAL). NC-PAL provides a range of services to help health care providers, child welfare agencies, and other community professionals address the behavioral health needs of children and families. NC-PAL services include:

- *Child Welfare Pilot Collaboratives*. NC-PAL clinical team members provide case reviews and consultation to pilot counties via "drop-ins" and group sessions on how to best apply evidence-based mental and behavioral health information in real-life situations.
- *Consultation to NC DHHS/ Rapid Response Team*. The NC DHHS Rapid Response Team (RRT) meets every weekday to collaboratively resolve the immediate needs of children in DSS custody. NC-PAL psychiatrists and psychologists participate in RRT to assist with case reviews when there are questions about psychiatric diagnosis, medication management, and/or best-practice psychotherapeutic intervention. NC PAL also provides medical record review and staff consultation as indicated.
- *REACH PPP*. NC PAL offers this a nationally recognized mental health training program to primary care providers in the state at no cost to participants.
- *Hotline*. NC-PAL behavioral health consultants field calls Monday through Friday to support health care providers with questions about the behavioral health needs of pediatric and perinatal patients.

3.7 Procedures and Protocols to Prevent Misdiagnosis

North Carolina relies on the following key documents to prevent children in foster care from being inappropriately diagnosed with mental illness, developmental disabilities, or other conditions or disorders and consequently placed in non-family foster home settings.

- *Best Practices for Medication Management for Children and Adolescents in Foster Care* provides child welfare workers, pharmacists, and prescribers with key information regarding medication oversight and monitoring, including “Reg Flag” and “High Alert” guidelines indicating the need for medication review. This publication includes a template to utilize when a child is transitioning to foster care or changing placements and outlines medication review pathways using a flow chart. *Best Practices for Medication Management* also includes questions for child welfare workers or resource parents to ask prescription providers.

- The companion *Psychotropic Medications in Children and Adolescents: Guide for Use and Monitoring* offers information for care managers, child welfare workers, and resource parents to use when they want to learn more about certain psychotropic medications. Specific information is outlined, including about each drug’s therapeutic class, brand and generic names, FDA approved uses, common evidence-based uses, potential side effects, and medication-specific safety/effectiveness monitoring necessary when a psychotropic medication is prescribed to a child or youth.

To ensure practice guidance is closely followed, NC DSS will continue to diligently monitor psychotropic medication use and misdiagnoses via case reviews that ask:

- Was this child seen regularly by a physician to monitor the effectiveness of medication, side effects, and/or health implications, and were changes considered as needed to dose or medication type, and/or determined whether medication is still necessary and or if treatment options would be more appropriate?
- Were regular follow-ups completed, and conversation and corresponding information with foster parent/caregiver about administering medicine and or child's experience with the medication (including side effects) noted in the record?
- Did the family follow state protocols related to the appropriate use and monitoring of medication?
- Were services put in place because of medical and or mental health team meetings? Were services tailored to the specific need of the child, and were they culturally appropriate?
- Were waitlists, lack of transportation, and/or other barriers noted in the file? Were appointments monitored and adjusted as needed to ensure the treatment goals are achieved and progress is made?

To provide further oversight of the use of psychotropic medication by foster children and ensure diagnostic information is adequately monitored across the state, NC DSS in concert with NC Medicaid will continue to oversee policies and procedures governing the prescription of psychotropic medications to children in foster care, including the following:

- Processes for reviewing criteria indicating a need to review the child/ adolescent’s clinical status to verify the medication regimen is accurate and appropriate.

- Data sharing agreements. Includes an agreement with NC Division of Health Benefits (NC Medicaid) to support monitoring of psychotropic medication at the state, regional, county, and individual level; and NC DSS access to Medicaid claims data for all children and youth who enter or remain in foster care.
- Informed and shared decision-making (consent and assent) and methods for ongoing communication between the prescriber, the child, the child's caregivers, other healthcare providers, the child welfare worker, and other key stakeholders.
- Effective medication monitoring at both the client and agency level.
- Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible Child and Adolescent Psychiatrist (at both the agency and individual case level).
- Mechanisms for sharing accurate and up-to-date information related to psychotropic medications to clinicians, child welfare staff, and consumers, including both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials. A form for use by child welfare staff and educational materials for child welfare workers (including webinars and practice guides) will be updated as part of the 2025-2029 HOCP.

3.8 Transition Plans for Youth Aging Out of Foster Care

In North Carolina, each youth in foster care transitioning to adulthood receives individualized support to transition successfully to adult health care. This process includes ensuring that high-quality, developmentally appropriate health care services are available in an uninterrupted manner as youth move from adolescence to adulthood. By utilizing the Foster Care Medical Home Model, providers and others involved can assist the youth and county child welfare workers in developing a plan for transition from pediatric care to adult care. Independent Living Services for Foster Children (i.e., NC LINKS) provides services and resources to youth and young adults ages 13-21 who are currently or formerly in the foster care program. NC LINKS Coordinators and county child welfare workers collaborate with youth to develop Transitional Living Plans (TLPs). As set forth in policy, the TLP must be developed, reviewed, and updated according to the following table.

Table 6. Transitional Living Plan Completion Requirements

Youth Turning 14	Youth Aged 14 or Older
• Developed no more than 30 days following the youth's 14th birthday; • Reviewed within 60 days of the youth's 14th birthday; • Updated at least every 90 days thereafter	• Developed within 30 days of the youth entering custody; • Reviewed within 60 days of the youth entering custody; • Updated at least every 90 days thereafter

The Transitional Living Plan (documented on forms DSS-5096b and DSS-5096c) helps ensure the health needs of youth aging out of foster care are met. Options about health insurance, including health insurance resources, provider information, and contact information for health care resources, are discussed in a youth-driven meeting. The resources identified are outlined on the corresponding forms. Additionally, the DSS-5096b and DSS-5096c are used to engage youth in conversation about the need for a health care power of attorney and/or health care proxy and to empower youth to execute such an agreement upon exiting care. The forms also document that the youth has received information or assistance regarding applying for Medicaid or other state/federally funded health insurance. When a youth ages out of foster care at age 18 or otherwise exits DSS custody, the agency must provide them with copies and/or access to their health records.

The Transition Age Youth (TAY) Workgroup, formerly under Fostering Health NC, is now a subset of the NC DSS Child Well-Being Design Team as of SFY 2023-24. NC DSS seeks counsel from the TAY group on various efforts intended to improve health care of youth and young adults in foster care. During the 2020-2024 HOCP, NC DSS worked with the TAY workgroup under Fostering Health NC to develop a one-pager about Medicaid benefits for youth transitioning to the adult care system. The TAY workgroup was also instrumental in putting together webinars to inform county DSS agencies about the healthcare power of attorney and Five Wishes tailored for youth exiting foster care.

In addition to adhering to policy surrounding foster youth becoming adults, NC DSS, through youth advocacy groups and LINKS coordinators, is committed as part of the 2025-2029 HOCP to:

- Maintaining the TAY Workgroup under the Well-Being Design Team, to ensure youth input when reviewing data and directing healthcare initiatives (“nothing about us, without us!”) and ensuring representatives from the TAY population have an active voice in the HOCP oversight.
- Working with other TAY groups and marginalized groups to support foster youths transitioning into adulthood.
- Working with NC Medicaid, the Well-Being Design Team, and LINKS coordinators to ensure all TAY are provided access to their own healthcare information and resources to support post-care enrollment in Medicaid, whether they are in- or out-of-state.
- Helping to implement the recommendations stemming from the NC DSS 2023 Regional Youth and Young Adult Listening Sessions.
- Maintaining and disseminating healthcare information as developed by TAY for TAY (e.g., the Medicaid one-page information sheet).

- Fully supporting the implementation of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271).
- Assisting with the development of an electronic health passport - to be embedded in the Children and Families Specialty Medicaid Plan (formally the Statewide Medicaid Managed Care Plan for Children and Youth in Foster Care).

4 Goals and Objectives for 2025-2029

Considering the data used to evaluate the state's performance, lessons learned, and newly implemented statewide initiatives set to roll-out across over the next five years, the goal and objectives of North Carolina's 2025-2029 HOCP are as follows.

Goal:

North Carolina will meet the physical, social-emotional, mental, and behavioral health needs of children, youth, and young adults served by its foster care program.

Objectives:

1. Uphold policies, practices, and healthcare-related services that pertain to children in NC's child welfare system,
2. Strengthen health programming for transition age youth (TAY), and
3. Ensure prescribing of psychotropic medication to children in foster care is safe and appropriate.

Measures: By the end of the 2025-2029 HOCP period:

4. 95% of cases reviewed will demonstrate diligent efforts to address children's physical health, dental health, and mental/behavioral health needs.
5. 95% of applicable cases reviewed will demonstrate adherence to policies and procedures pertaining to the health of transition aged youth.
6. 95% of cases reviewed will demonstrate adherence to policies and procedures for monitoring the use of medication and oversight of psychotropic medication use by children in county DSS custody.

Objectives	Interventions	Benchmarks	Timeframe
Objective 1: Uphold policies, practices, and healthcare-related services that pertain to children	Monitor healthcare service utilization by children in county DSS custody across regions to ensure 7-day, 30-day, Well-check, and follow-up appointments are	Conduct cross-system data analyses annually to determine level of healthcare service utilization and identify emerging needs, including monitoring	Years 1-5

in NC's child welfare system.	completed for each child in care pursuant to federal and state policies.	needs of young children, particularly for those diagnosed with autism, IDD, ADHD, and asthma.	
	Increase availability of healthcare services (including dental care) in rural and underserved areas of the state.	Continue to promote the use of the Medical Home model, and care management.	Years 1–4
	Implement trauma-informed assessment and trauma-informed tools statewide.	Collaborate with North Carolina Office of Rural Health Dental Health to support efforts to increase dental practices across North Carolina.	Years 1–2
		Develop a FC TIA by 2026	Years 2–3
	Promote other statewide initiatives that monitor placement and levels of care across age and race demographics (e.g., numbers and demographics of youth recommended for PRTF level of care), and that aim to improve the physical, dental, and mental and behavioral well-being of all	Require the use of the Project Broadcast trauma tools by all counties by December 2025 and require enhancing trauma-informed care across the continuum of foster care for children of all ages.	Years 1–5

	children, youth, and young adults in care.		
Objective 2: Strengthen health programming for transition age youth (TAY).	Fully implement the SUPPORT Act.	Work with NC Medicaid to complete system functionality, policy updates, and monitoring to allow for former foster youth who have moved to NC from another state, who are eligible for Medicaid under the Act.	Years 1-2
	Update the TAY healthcare one-pager and healthcare power of attorney (POA) documents as needed.	Partner with SaySo, LINKS, and the CFSP Well-Being Design Transition Age Youth Workgroup to provide training to caseworkers on the healthcare needs of youth in transition to adulthood, to include the providing information about Medicaid and the Healthcare POA.	Years 2-4

	Develop electronic health records for foster youth and create a healthcare passport for youth aging out of care.	Partner with NC DHHS agency partners to stand up the healthcare passport for foster youth as part of the Children and Families Specialty Plan (CFSP). Engage Medicaid, NC LINKS, and others to ensure all TAY have access to their own healthcare information and resources to support post-care enrollment in Medicaid.	Years 3-5
Objective 3: Ensure prescribing of psychotropic medication to children in foster care is safe and appropriate.	Strengthen mechanisms for overseeing psychotropic medication use.	Engage the NC DSS Child Well-Being Design Team in ongoing dialogue to gain insight into prescribing practices and their impact.	Years 1-2
		Continue to monitor documentation in case records pertaining to medication.	Years 3-5
	Build statewide capacity to ensure prescribing of psychotropic medication to children in foster care is safe and appropriate.	Partner with NC-PAL to train child welfare agencies, PCPs, pharmacists, mental health providers, and caregivers about medication use, collaboration and informed decision-	Years 1-3

		making, and strategies to prevent misdiagnosis.	

5 Supporting Information and Documentation

5.1 Key Resources

- AAP Standards of Care
  https://www.aap.org/en/patient-care/foster-care/health-care-standards/
- Health Check Guide
  https://medicaid.ncdhhs.gov/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services
- ACF Guidance ACF Medication Guidance
  https://www.acf.hhs.gov/sites/default/files/documents/cb/im1203.pdf
- Office of Inspector General: “Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication”
  https://oig.hhs.gov/oei/reports/oei-07-15-00380.pdf
- “Mental Illness in Foster Youth: The State of Psychotropic Medication Prescribing in North Carolina,” and “Psychotropic Medication Use in Foster Youth” by Kimberlee Grier, Dean Duncan, Richard Chung, Lindsay Terrell, Ashleigh Harlow, Debra Brandon, Rosa Gonzalez-Guarda
- Rural Health Information Hub. (n.d.). *Health professional shortage areas: Dental care, by county, April 2024 - North Carolina*.
  https://www.ruralhealthinfo.org/charts/9?state=NC
- North Carolina Office of Rural Health. (2023). *Dental health—health professional shortage areas (HPSA)*. https://www.ncdhhs.gov/dental/download

5.2 Acknowledgements

The NC 2025-2029 HOCP was developed in concert with the NC Department of Health Benefits (NC Medicaid) and in consultation with pediatricians and other experts in health care, child welfare experts, and recipients of child welfare services, as part of NC DSS Child and Family Services Plan (CFSP) Children’s Well-Being Design Team. Collaborative efforts involved county DSS directors and managers and representatives from juvenile justice representatives, community-based health care providers, and managed care entities as well as transition age youth and other stakeholders with lived experience. A special thanks to the North Carolina Pediatric Society, Inc., the Fostering Health NC project, the Child and Family Well-Being Team, Community Care of North Carolina, the Center for Child and Family Health, NC Medicaid, Transition Age Youth Workgroup, and Family Partners for their tireless contributions to this important work.

5.3 Public Notice

This 2025-2029 Health Care Oversight and Coordination Plan (revised 2024) is posted on the Program Statistics and Reviews page of the North Carolina Division of Social Services website at https://www.ncdhhs.gov/divisions/social-services/program-statistics-and-reviews/child-welfare-statistics. Progress implementing this Health Care Oversight and Coordination Plan can be found in the state's most recent Annual Progress and Services Report (APSR) located at https://www.ncdhhs.gov/divisions/social-services/program-statistics-and-reviews/child-welfare-statistics.

5.4 Comments or Questions

Comments of questions about this plan should be directed to:

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