NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES
HEALTH CARE OVERSIGHT AND COORDINATION PLAN
2020-2024
Updated June 2023

Health Care Oversight and Coordination

The New Jersey Department of Children and Families' (DCF) Office of Integrated Health & Wellness (OIHW) is charged with providing support, guidance and leadership across DCF on child and family health-related matters. OIHW supports the overall safety and connectedness of children and families served by the Department and supports DCF's child welfare-serving Division of Child Protection & Permanency (CP&P) to ensure families and children achieve appropriate physical and behavioral health outcomes.

New Jersey Health Care Oversight and Coordination Plan for 2020 – 2024

Through the original Coordinated Health Care Plan for children in out-of-home placement created in 2007, which was finalized shortly after DCF was established as a cabinet-level Department, DCF was able to reform the health care system for children in placement by assessing service gaps, areas of strength, and areas in need of improvement. The assessment, which relied on data collection and analysis, system mapping and best practice review, revealed that, while there were pockets of excellence and promising practices in New Jersey, fragmentation of health care services and lack of coordination were the largest challenges.

This work led to the development of a structured model to ensure that the primary and preventive health care needs of children entering out-of-home placement are met. The development of the Coordinated Health Care Plan and teaming with Rutgers University provided DCF the ability to build the capacity to provide comprehensive and continuous coordination of quality health care case management to support the needs of children in placement within the 46 CP&P Local Offices. As part of this capacity-building, DCF and Rutgers University staff focused on continuity of care for children from the time they enter placement until they exit care, engagement of biological family in health care planning and follow-up, and the appropriateness and timeliness of mental/behavioral health care services.

Overview: Child Health Care Case Management in New Jersey

The child health care case management model was designed to ensure that all the medical and behavioral health needs of children in placement are met. DCF collaborated with its federal monitor, child welfare nursing staff, and the former New Jersey Office of the Child Advocate to establish standard measures to track medical and behavioral health care outcomes for children in out-of-home placement. These child health measures were developed to support DCF in building a cohesive system that could meet and achieve the identified child health performance goals. The move towards standardized measurement was critical to DCF's efforts to ensure the medical and behavioral health care needs of children in out-of-home placement are addressed. DCF's performance data were designed to measure, identify and address the needs of a child at the onset of entering out-of-home placement and throughout their placement episode,

monitoring each child's progress, needs and developmental milestones. Child health measures are also significant as they represent a combination of timely identification and attention to health care issues of children in placement. These measures ensure consistent and ongoing quality health care, which supports several priorities of DCF's Strategic Plan.[1]

DCF created Child Health Units (CHUs) to ensure medical and behavioral health care measures would be achieved over time for children in placement. The CHUs were developed with the vision of embedding nursing staff into the culture of the CP&P local offices to collaborate with case workers, other local office staff, and kin and unrelated resource families. Another objective was to provide local offices with consultants who possess the expertise and knowledge needed to navigate through the various facets of the health care system. The CHUs provide CP&P with the ability to ensure seamless coordination of services, as well as proper review and follow-up of medical records and assessments. Nursing staff ultimately became responsible for completing and tracking the progress for all health-related duties previously performed by CP&P caseworkers. This philosophy is supported by the American Academy of Pediatrics (AAP), which stated, "health care management is the responsibility of the child welfare agency, but it is a function that requires medical expertise."[2]

The CHU nursing staff responsibilities include, but are not limited to the following:

- Perform Pre-Placement Assessments (PPA),
- Obtain and review medical records,
- Ensure comprehensive medical exams (CME) are conducted and immunizations are up to date,
- Complete mental health screenings,
- Monitor psychotropic medications and treatment,
- Assign an acuity level to every child who enters placement,
- Manage individual health care case management records,
- Work collaboratively with managed care organization care managers,
- Perform routine in-person contact with children and caregivers, developmental monitoring and follow-up,
- Work closely with resource families on a continuous basis to follow-up on all recommendations and ensure they are resolved,
- Team with staff and partners to support transparency, seamless services and system capacity to identify trends related to child health outcomes, and
- Prepare and provide Child Health Passports to resource parents.

The CHUs were a cornerstone of DCF's early reform efforts, and they have built upon this foundation to enhance trauma-informed practice in New Jersey. The CHUs proactively ensure that New Jersey's child health care case management model remains a national model for children in out-of-home placement. Work done by OIHW, Rutgers University

[1] https://www.nj.gov/dcf/about/DCF-strategic-plan-narrative_2019-2020.pdf

[2] American Academy of Pediatrics (AAP). Fostering Health: Health Care for Children and Adolescent in Placement. 2nd Ed. 2005

and the nursing staff at the local office level provides comprehensive oversight of children in placement to ensure the child health outcome foundational elements continue to be maintained. The measures highlighted in Figure 1 and presented throughout the remainder of this plan reflect well-child and preventive care best practices.

Figure 1

Child Medical Health Measures	Child Behavioral/Mental Health Measures
• PPAs • Appropriate medical assessment and treatment- CMEs • Follow-up care and treatment • Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • Immunizations • Dental examinations	• Mental health screening • Mental health assessment • Follow-up care and treatment

Schedule for Initial & Follow-Up Health Screenings

Pre-Placement Assessments

Safety and stability are two of the primary concerns assessed by child welfare and protection staff. A significant aspect of ensuring a child is safe and stable is providing thorough health care case management, including timely screening and assessment. As part of New Jersey's Coordinated Child Health Care Plan, all children are required to receive a PPA within 24 hours of removal from their home.[3] The purpose of this assessment is to evaluate the health status of the child at the time of removal, identify, document and develop a plan to address the child's immediate (urgent and non-urgent) health care needs, document injury if present, and ensure each child is free from contagion. Assessments also identify conditions that might inform decision-making about the most appropriate care setting for the child.[4] PPAs are conducted by professionals and in environments that minimize additional trauma surrounding placements: the child's own health care professional, CHU nurse in a CP&P local office, specially designated health care professional, such as pediatricians or Federally Qualified Health Centers within the local CP&P community, or, in very limited circumstances, a hospital emergency room.

PPAs allow CP&P to obtain information for children entering placement regarding their current physical and behavioral health status. These assessments assist the CHU nurses, CP&P caseworkers and resource caregivers to ensure the child's immediate physical and behavioral health care needs are identified, understood and addressed to help minimize the trauma of entering placement. During FY2018 and FY2019, there was a 97% completion rate for PPAs both completed and in appropriate settings. From FY2020 through FY2022, this increased to a 98% completion rate for PPAs in an appropriate setting.

[3] The only exception is when a child enters placement from a medical setting. See DCF Policy Manual CP&P-V-A-1-1300

[4] Ibid.

During the COVID-19 public health emergency, from mid-March to July 2020, PPAs were completed by pediatric offices and urgent care settings with the child's primary pediatrician as the preferred setting. The Child Health Program provided statewide provider lists for open and available appointments in-person and telephonically to complete PPAs during this time. From July 2020 to present, PPAs are again offered by the CHU nurses in the CP&P Local Office. COVID-19 positive youth or a youth designated as a person under investigation are assessed by the CHU nurse and alternative PPA arrangements for an appropriate setting are made, including the primary care physician or urgent care settings.

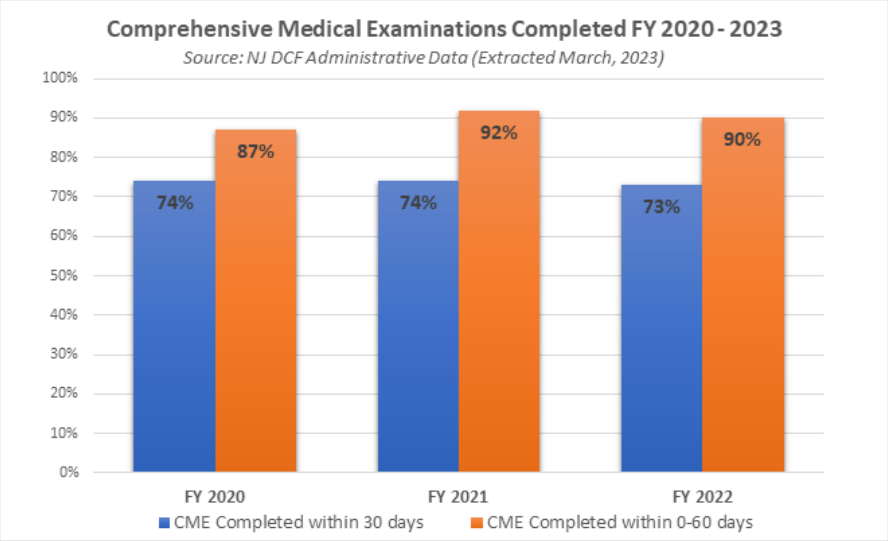
Comprehensive Medical Examinations

DCF's responsibility and commitment to ensuring children who enter a CP&P placement receive a full medical and behavioral health assessment is embedded into the health care case planning and management. This level of screening allows CHU nurses, front line staff, and professionals, e.g., physicians, social workers, and therapist, to identify and screen current and past medical and behavioral health concerns, including Adverse Childhood Experiences (ACEs). To ensure the most thorough approach to screening is utilized, the CME process was developed to ensure all children entering placement receive services and access care to address any identified needs.

Within 30 days of entering out-of-home care for the first time, every child must have a CME. A CME is a full medical assessment that provides an overview of the child's current status, physical and developmental history, medical record review based on what is available, an initial mental health screening and physician recommendations. CMEs are provided by the state's Regional Diagnostic and Treatment Centers (RDTCs), a contracted community-based provider, or the child's primary care physician. CHU nurses are responsible for scheduling CME appointments and ensuring all necessary parties, i.e., caseworker, resource parent, etc., are available, and for gathering all required documents and preparing all applicable physical and behavioral health information for individual physicians and therapists. Through a partnership with the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS), the state Medicaid agency, contracted providers are entitled to receive an enhanced rate from Medicaid for performing the CME and are required to complete two forms to document the service: an initial report at the time of the visit, and the final report within 14 days.

CP&P has historically maintained steady performance with regard to timely completion of CMEs. Since FY2019, CP&P has maintained steady performance with the majority (77% average) of children receiving a CME within 30 days of entering out-of-home care, and an overall 92% of CMEs being completed within 60 days. Figure 2 displays the timely completion of CMEs within 30 days of entering out-of-home care and within 60 days of entering out-of-home care for the past three years. FY20 and FY21 CME completion in 0-60 days were impacted by the COVID-19 emergency.

Figure 2



As an initial response to the pandemic and public health emergency, the RDTCs offered a combination of in-person and telehealth appointments for the CME. Medical services are currently provided in-person. The RDTC's implementation of health and safety procedures specific to preventing the spread of COVID-19 supported successful continuity of operations.

Mental Health Screenings

Because trauma exposure rates are nearly 90% among children in placement,[5] initial and ongoing screening and assessment are instrumental to identify and assess the overall needs of children with child welfare involvement who enter placement. Routine and regular screenings allow child welfare agencies to evaluate a child's needs on a continuous basis and to ensure they receive safe and appropriate supports and services. The screening of children that enter placement is also supported on a broader level, as child welfare agencies throughout the United States are incorporating screenings to assess trauma and other behavioral health care needs.

DCF uses screenings to inform practice, identify appropriate services and placements, and to equip caregivers with background information that assists them to understand and care for the individual trauma experiences and needs of the child. Using data from screenings and assessments is supported by research that suggests this approach allows child welfare systems to assess the efficacy of supports and services for individual children and the overall population being served.[6] CP&P recognizes the trauma children experience when removed from their homes and understands background information

[5] U.S. Department of Health and Human Services. (2013, July 11). [Letter to State Medicaid Directors]. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf. Retrieved November 16, 2018.
[6] Ibid.

can be limited. As a method of best practice, each child entering a CP&P out-of-home placement receives a mental health screening to determine if a mental health assessment is needed. Behavioral and mental health screenings assist with learning about a potential history of trauma and determining if a child has an identified or suspected mental health need.

Each child that enters out-of-home placement in New Jersey receives an initial mental health screening by a qualified professional. Children entering placement are screened utilizing at least one of the three following options:

- Screening by a CHU nurse utilizing the Bright Futures Pediatric Symptoms Checklist,[7]
- Screening by the physician/health care practitioner conducting the CME, utilizing their identified developmental screening tool, or
- Screening by a CP&P caseworker using a tool developed by DCF, which has been adapted from the Mental Health Screening Tool developed in California.[8]

Since 2016, CP&P has partnered, through DCF's Children's System of Care (CSOC), with the state's providers of Mobile Response and Stabilization Services (MRSS) to provide services to children and resource caregivers at the time of placement. The main goal of this initiative with MRSS is to facilitate stabilization and mitigate trauma for children/youth at time of placement by offering support and education to children/youth and licensed resource and kinship caregivers. Support and stabilization are important factors in avoiding re-traumatization that can occur from further changes to placement.

The MRSS is CSOC's urgent response component, and providers offer 24/7 response to children/youth experiencing crisis, as defined by their family, with a goal of stabilization by providing supports and services within the CSOC framework. This initiative requires CP&P staff members to contact CSOC's Contracted System Administrator, which is CSOC's single point of entry and access to care, to refer all children/youth ages three through 18 that are being placed in resource or kinship care to the MRSS. This connects children/youth and caregivers to their local MRSS provider for intervention, assessment, and planning, if the Care Management Organization (CMO) is not already involved with the child at the time of placement.

MRSS is also delivered to children and youth vulnerable to or experiencing stressors, coping challenges, escalating emotional symptoms, behaviors or traumatic circumstances that have compromised or impacted their ability to function at their baseline within their family, living situation, school and/or community environments. These family-defined crises arise from situations, events, and/or circumstances that are unable to be resolved with the usual resources and coping abilities and jeopardize the development of adaptive social and emotional skills. Without MRSS intervention, children and youth may require a higher intensity of care to meet their needs, and may be at risk of psychiatric hospitalization, out-of-home treatment, legal charges, or loss of their living arrangement, including out-of-home placement through CP&P. In particular, children and

[7] https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
[8] http://www.cebc4cw.org/assessment-tool/the-mental-health-screening-tool/

youth that have experienced implicit or explicit trauma, and do not receive timely and appropriate services, may be at increased risk for an acute decline in their baseline functioning or for being in jeopardy of a change in their current living environment.

Resulting from the COVID-19 pandemic, DMAHS issued guidance regarding the use of telehealth to provide medically necessary Medicaid services. In December 2021, the New Jersey State Legislature enacted legislation extending telehealth flexibilities through December 31, 2023. Additionally, DCF provider guidance and telehealth standards were developed to support quality telehealth service delivery. Current guidance directs that MRSS service delivery method be available in person as the primary and preferred engagement method, and allowing telehealth service delivery when families request, recognizing families' individual needs, circumstances and perspectives.

MRSS programs continue to receive referrals at a record volume related to increased needs experienced by youth and families and current mental health crisis. MRSS programs and agencies have employed numerous creative strategies to continue quality operations and recruit qualified employees during this period of historic demand and continued work force capacity challenges. CSOC continues to support the MRSS programs by exploring additional strategies for allowable flexibility in service delivery approach and efficiencies in processes surrounding MRSS work.

Monitoring Follow-Up Care

DCF conducts a case record review process every six months for reporting follow-up specific to specialty care needs of children entering placement. The Health Care Case Record Review also reports on indicators not typically captured from DCF's other data sources and involves reviewing a random sample of CHU health care records. Through these ongoing health care case record reviews, DCF analyzes recommended follow-up care and treatment identified in CMEs, mental health screenings, assessments and timely delivery of this information to resource parents. DCF discusses and analyzes best practices related to effectively addressing follow-up care and identifying any potential gaps in provision of follow-up care services that could be rectified. DCF is able to distinguish cases for which only some of the follow-up care needs can be addressed and determine if barriers are due to community or internal challenges.

One of the primary functions of DCF's health care case management model is to continually assess coordination of services and each child's ability to access and receive quality medical and behavioral health care and follow-up care services. The monitoring work conducted through the Child Health Program (CHP) for DCF is represented throughout the remainder of this plan.

Mental Health Assessment

Mental health assessments provide a comprehensive and detailed evaluation of a child's current mental health and help to determine follow-up care and treatment. Mental or behavioral health or psychiatric services children are receiving at the time of placement are confirmed by CP&P and/or the CHP to ensure children are receiving regular screening, re-evaluation, and treatment. However, additional concerns may present

themselves that warrant a referral for mental health assessment following placement to assist with ensuring appropriate services and supports are being provided to each child.

Follow-up related to Medical Health Care
The PPA and CME identify if children entering placement need immediate follow-up care or treatment related to their health care needs. The CME also provides necessary recommendations for CHU nurses and CP&P staff members to ensure children in placement receive ongoing follow-up care with appropriate primary and specialty services. Follow-up care and services are essential components to ensure the identified medical needs of children in placement are addressed and met on a continuous basis.

During the public health emergency, CHP developed a COVID-19 Management Plan for PPAs and home visitation for a standard and consistent approach across the state. From mid-March to July 2020, telephonic pediatric nursing assessments with the resource parents/caregivers were established. This telehealth approach allowed for the nurses to continue providing the pediatric nursing assessment remotely, while reviewing upcoming medical visits, and to identify providers offering telehealth and in-person appointments. In July 2020, the nursing staff returned to the field providing in-person assessments and PPAs. As pediatric offices reestablished office hours and alternative locations for well and sick visits, the nursing staff continued to provide assistance and planning for catch up appointments and rescheduling.

Updating and Appropriately Sharing Medical Information
Similar to caseworkers, CHU nurses are mandated to have face-to-face contact with all children in placement and their caregivers. The schedule for these contacts is based on the child's acuity level, which is guided by their current and up-to-date health needs. At a minimum, CHU nurses have initial contact with the child and caregiver within two weeks of placement, followed by quarterly ongoing visits. CHU nurses are available to answer questions regarding the child's health care needs from caregivers and to help plan follow-up care with treating medical providers.

As health information is gathered, it is maintained within the NJ SPIRIT data system, DCF's comprehensive child welfare information system. NJ SPIRIT includes specific areas in which information related to a child's medical and mental health should be recorded. These electronic windows within NJ SPIRIT are primarily used and updated by the CHU, however CP&P caseworkers also have access to record significant health-related information. All information recorded within the medical and mental health windows of NJ SPIRIT become part of the child welfare case record. There is also the ability to upload pertinent medical documents directly into NJ SPIRIT.

Since April 2011, CP&P adopted use of the Health Passport and Placement Assessment form (Health Passport). The forms are accessed and updated through NJ SPIRIT. CHU nurses complete Health Passports within 72 hours of beginning health care case management. A copy of the Health Passport is provided to the CP&P caseworker and child's caregiver within five days of placement. It includes general age-appropriate and child-specific anticipatory guidance that can be utilized by the CP&P in making a safe placement decision and to alert the child's health care practitioner to health needs.

The Health Passport is updated after every face-to-face contact the CHU nurse has with the child and provides a current summary of nursing assessment, acuity level, caregiver requirements, and a short-term follow-up health plan. CHU nurses update any medical or behavioral health changes to the child's Health Passport in NJ SPIRIT, as needed, and distribute updated versions to the child's caregiver. The up-to-date Health Passport is also provided to an adolescent who is exiting care at or beyond age 18. The following information is also reflected and maintained in the Health Passport if known:

- significant birth history,
- history of hospitalizations, injuries and/or illnesses,
- significant childhood diseases,
- developmental history,
- education classification,
- counseling services,
- family medical history,
- all medical providers, and
- types and results of medical/laboratory testing.

Ensuring Continuity of Health Care Services

Establishing a medical home for every child in placement is an on-going consideration within DCF and OIHW. Efforts are made to provide for continuity of care to the extent possible. When feasible, each child's care continues to be provided by the primary care physician (PCP) utilized prior to placement. When that cannot occur, the substitute caregiver is encouraged to connect the child to a PCP as soon as possible following placement. To the extent possible, the child is maintained in the same health maintenance organization (HMO) so coverage for and access to required services remains. Communication between and among the CHU, CP&P caseworker, HMO care manager, placement family, and family of origin is encouraged and facilitated through the CP&P Case Practice Model.

Psychotropic Medication Policy & Practice and Mental Health Initiatives

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

Published in 2017,[9] DCF developed a comprehensive policy concerning the prescription, use and monitoring of psychotropic medication for DCF involved children and any child in CP&P custody. DCF's goal is to ensure the policy helps position the Department and its partners to promote good practice in the interest of better serving children and families. Key components of the policy include criteria for informed consent and treatment plans, appendices about psychotropic medication parameters to be used when considering consent for treatment, Psychotropic Medication Safety Monitoring Guidelines, and additional resources for CHU and CP&P staff.

The OIHW participated in the Center for Health Care Strategies, Inc. Psychotropic Medication Quality Improvement Collaborative project throughout FY 2016. At its

[9] https://www.state.nj.us/dcf/policy_manuals/CPP-V-A-1-1500_issuance.shtml

completion, New Jersey's goals of monitoring psychotropic medication utilization and improving compliance with components of the New Jersey Psychotropic Medication Policy continued to provide information about trends, identify areas for further study, and demonstrate compliance. This targeted review has been strengthened by the establishment of a process for follow-up of individual children and youth identified for review in collaboration with the nursing team. Increased capacity in NJ SPIRIT to capture additional information regarding psychotropic medications has been added, and the work toward a strategy to crosswalk data between CHU and CSOC continues.

CHU nurses maintain information in NJ SPIRIT for medications prescribed to children in placement, including psychotropic medication. The information maintained in NJ SPIRIT for psychotropic medications includes the diagnosis for which each medication is prescribed, the presence of a signed consent for each medication and verification of a treatment plan with non-pharmacological interventions. This information is downloaded quarterly into a report for OIHW and is reviewed by the CHU. Children are monitored by age and number of prescribed psychotropic medications. Reports are submitted for additional review by DCF's Child and Adolescent Psychiatrists, and the CHP Advanced Practice Nurse (APN) for child behavioral health. All children who present with additional risks, such as children under age six and those on more than four medications, are reviewed individually.

OIHW identified a need to enhance capacity for monitoring adherence to the DCF Psychotropic Medication Policy by staffing an APN/Certified Pediatric Mental Health Specialist through CHP to work collaboratively with the child and adolescent psychiatrists. The APN has provided increased monitoring and oversight ensuring ongoing adherence to DCF's psychotropic medication policy, with an emphasis on analysis of system-wide and sub-population data to support quality assurance and quality improvement activities. It also provides CP&P leadership with meaningful data on local and statewide trends. This measure increased the focus on adherence to non-pharmacological medication treatment requirements, as well as increased compliance and collaboration among providers, CP&P, and the nursing team. Training for workers to build their knowledge base on psychotropic medications and enhance their capacity to empower parents to ask appropriate questions regarding this topic was developed by University Behavioral HealthCare. This curriculum is implemented in the training of CP&P, CSOC, and CMO staff.

Engagement of Community Medical and Non-Medical Professionals Pediatricians

DCF contracts for the services of pediatricians who, working through one of the RDTCs, are available to assist CP&P staff. They conduct medical chart reviews, strategize with CP&P and CHU staff on addressing care for children with particularly complex health issues, provide guidance around consenting for non-routine medical procedure, and serve as liaison between health care providers and CP&P Local Offices to address emergent issues and concerns. Additionally, they provide 24/7 phone access to CP&P field staff and the screening center.

DCF Child/Adolescent Psychiatrists
DCF contracts with one full-time and one part-time Child and Adolescent Psychiatrist that provide guidance and training on the identification, evaluation, diagnosis and treatment of children and youth with mental health needs and conduct medical chart reviews. They also engage in dialogue with providers regarding specific children and their appropriate treatment plan and provide daily guidance and support to CP&P local office staff through case consultation. The Child and Adolescent Psychiatrists provide leadership around quality assurance efforts in the area of psychotropic medication utilization and ongoing efforts to strengthen DCF's psychotropic medication policy and practice and assist in the development of the CP&P Mental Health Screening Program.

DCF Pediatric Neuropsychologist
The DCF contract for a full-time pediatric neuropsychologist consultant was terminated in September 2020 based on operational needs. Through collaboration among CP&P, PCPs, and the CHP, access to appropriate evaluation services for children is being maintained. CP&P has fee-for-service contracts with private neuropsychologists for evaluation and consultant services as needed.

Regional Diagnostic and Treatment Centers
RDTCs in New Jersey are legislatively mandated to provide diagnostic and treatment services to alleged and confirmed child victims of physical abuse, sexual abuse, and neglect. CP&P refers children for whom there are concerns of abuse or neglect to the RDTC for evaluation and treatment to ensure children who may be victims of child abuse/neglect have access to medical and mental health evaluations by professionals with specialty training in child abuse and neglect and trauma. The services provided by the RDTCs also guide CP&P's case practice and decision-making. RDTCs receive funding from DCF to provide psychological and medical evaluation, treatment of child abuse/neglect, provide thorough reports and expert testimony, engage with county-based multidisciplinary teams, and provide training and consultation services. These centers are also contracted to conduct CMEs and Comprehensive Mental Health Assessments for children entering resource placement.

Resulting from the COVID-19 public health emergency, DCF temporarily authorized the provision of specific services via remote technology on March 24, 2020, after legislation was signed on March 19, 2020, authorizing telemedicine and telehealth services for the duration of the public health emergency. As an initial response to the pandemic and public health emergency, the RDTCs offered a combination of in-person and telehealth appointments for the CME. Medical services are currently being provided in-person. The RDTC's implementation of health and safety procedures specific to preventing the spread of COVID-19 supported successful continuity of operations.

DCF created standard language contract documents for the RDTCs to support consistency in practice and equitable access to RDTC services across the state. Implementation of the new standard document with the RDTCs began in December 2020 and communication and collaboration will continue to support the RDTCs ability to

adapt to the contract deliverables. In addition to the standard language documents, DCF created a standard referral form in 2021 for CP&P to use for all RDTCs.

Multi-Disciplinary Treatment Teams

CP&P staff, in addition to medical personnel from the state's RDTCs and law enforcement, participate in Multi-Disciplinary (MDT) teams charged with reviewing individual children's cases and determining how to meet the child victim's needs. CSOC also collaborates with system partners at the local and state level to interpret results data and identify areas of growth and need to best support informed decision-making and planning. CSOC partners with the New Jersey Department of Human Services and County Inter-Agency Coordinating Councils (CIACCs), which are local county-based planning and advisory groups that foster cross-system service planning for youth with behavioral and emotional health needs, substance use, and/or intellectual and developmental disabilities and their families. CIACCs provide a multidisciplinary forum to develop and maintain a responsive, accessible, and integrated system of care for youth and their families through the involvement of natural family supports, child-serving agencies, local system partners, community-based organizations, county planning entities, and state representatives and partners. Partnerships like these assist DCF with identifying trends, strengths, and areas in need of improvement for effective service delivery and maintenance of a comprehensive system of care as well as sustaining collaborative accountability.

Forensic Evaluation Services by Psychologists

DCF's *Guidelines for Evaluations in Child Abuse/Neglect Proceedings*, the Department's first comprehensive effort to address the use of expert evaluations in child welfare and child protective services proceedings, were adopted as policy in November 2012. The guidelines present best practices for forensic evaluations and assessments that may be needed during child welfare and child abuse/neglect investigations, or to assist with permanency planning. The Guidelines are intended to improve the quality and utilization of expert forensic evaluations provided for CP&P and the courts. OIHW worked with the Office of Training and Professional Development (OTPD) to design and implement a day-long course for CP&P case workers and supervisors to support implementation of DCF's Guidelines for Evaluations in Child Abuse/Neglect Proceedings. The training is intended to strengthen understanding among CP&P staff about the role of forensic evaluations, including when to use them, how to formulate quality and appropriate evaluation questions, what information to provide to evaluators, and what to expect in terms of a deliverable.

Following the release of the Guidelines, DCF issued its first Request for Qualifications (RFQ) for Forensic Evaluation Services by Psychologists in December 2012 as a means of expanding the existing pool of psychologists that perform forensic (mental health) examinations. The RFQ was designed to increase the number of resources available to CP&P and to improve upon the quality of psychologists by establishing some minimum standards. The RFQ is updated and reissued as needed.

From July 2015 to June 2020, Rutgers University was contracted to create DCF's Coordination Center (NJCC) for Child Abuse and Neglect Forensic Evaluation and Treatment to assist the Department, the RDTCs, and other providers conducting forensic evaluations and providing treatment recommendations for the Department by:

- Ensuring that CP&P children and families have access to Centers of Excellence in the area of child abuse and neglect assessment and treatment within New Jersey,
- Supporting and disseminating best practices to improve the quality of child abuse and neglect assessment/evaluation and treatment,
- Training, coaching, and providing technical assistance to the forensic evaluation provider community,
- Advancing understanding and scholarship in the area of child abuse assessment, and
- Assisting DCF with ongoing planning activities in the area of child abuse neglect evaluation and treatment.

In May 2019, the NJCC completed a Quality Improvement Study (QI-Study) which offered a systematic, peer-reviewed examination of forensic evaluations conducted by psychologists under contract with DCF. The reviewed forensic evaluation reports represented a sample (1,643; 17.4%) of those prepared by contracted service providers, including private psychologists and those employed within the network of RDTCs, across the 46 CP&P local offices between July 2015 and March 2018. The NJCC held dissemination meetings after reviews were completed for each catchment area. The dissemination meetings served to review the findings of the quality reviews, discuss areas of strengths and needs, and allowed CP&P and the providers to reflect on their own practices and how they could improve service delivery. The input gathered from participants, in addition to the findings of the QI-Study, has informed the development of trainings, practice, and deliverables.

The NJCC published multiple brief reports on the use of psychological assessment tools/measurements, quality referral questions and recommendations, and cultural competency that are were shared virtually and during in-person events with psychologists and child welfare professionals. The NJCC also developed an e-learning product on cultural competency that was approved for social work and psychology continuing education credits. Additionally, the NJCC launched a lecture series:

In June 2019, the lecture, *Toward Improving Quality: Effectively Assessing Domestic Violence in Child Welfare Cases,* was held in two locations in New Jersey, and, in December 2019, the lecture, *Toward Improving Quality: Effectively Assessing Substance Use in Child Welfare Cases,* was provided in three locations across the state. Continuing education was offered for all attending professionals.

The OIHW continues efforts to improve and support the work of child welfare and mental health professionals. Specific efforts include the development of the Guide to Seeking Clinical Evaluation, a universal referral form for clinical evaluation services reviewing professional organizations' best practice standards to inform service expectations, and critical thinking related to decision-making and utilization of evaluations.

Following the completion of the QI-Study, the NJCC conducted a focus group with a sample cohort of peer reviewers who participated in the QI-Study which identified and reinforced the findings from the QI-Study and dissemination meetings.

Resulting from the COVID-19 public health emergency, DCF temporarily authorized the provision of specific services via remote technology on March 24, 2020, after enabling legislation signed on March 19, 2020, allowed telemedicine and telehealth services for the duration of the public health emergency. DCF's guidance for CP&P and providers related to mental health assessments and evaluations provided that forensic evaluations in child protection are often 'high-stakes evaluations' and used to inform litigation decisions; therefore, forensic evaluations were to be conducted in-person.

Procedures and Protocols to Ensure Children in Placement are not Inappropriately Diagnosed

In New Jersey, the building of a systematic, well-resourced approach for supporting families of children under the age of five is being explored. DCF is working with Advocates for Children in New Jersey (ACNJ) and a team of public and private sector leaders, supported by early childhood experts, to implement an action plan to ensure 25% of low-income infants and toddlers in New Jersey, approximately 27,000 young children, have access to high-quality services by 2023.[10] Priority services include childcare, home visiting, health and mental health services. The plan, supported by a grant from the Pritzker Children's Initiative, provides specific targets for impact and financing for each area. DCF is a critical partner in this effort and is identifying opportunities to expand infant mental health services for at-risk families involved with CP&P, including those with a young child in out-of-home placement and ones served in their own homes.

CSOC partners with the Center for Autism and Early Childhood Mental Health at Montclair State University to provide professional development opportunities for agencies contracted through CSOC. Long-term outcomes include:

1. optimal infant and early childhood social and emotional development and family well-being,
2. a sustainable, statewide, qualified, reflective, and relational multi-disciplinary infant and early childhood workforce as well as collaboration, and
3. collaboration, integration, and earlier intervention by system partners in seamless System of Care for Infant and Early Childhood Mental Health.

The current "Birth to Five: Helping Families Thrive" initiative aims to increase system capacity to provide effective mental health interventions for infants and young children through a competent and confident workforce, that strengthen caregiver/child connections, ensure parents and caregivers have the skills and resources necessary to support the healthy social and emotional development of their children, and reduce the need for higher intensity treatment interventions at a later age as well as unnecessary system involvement. Additionally, it will build cross system knowledge in this area and

[10] Additional information is available at: https://acnj.org/issues/early-learning/birth-to-three/pritzker-childrens-initiative.

system level connections and relationships which will enhance and strengthen the ability to support individualized service delivery and support.

Through this multiyear initiative, cohorts of mental health clinicians and frontline MRSS staff are being trained in an infant mental health framework and reflective practice. Clinicians receive additional training and certification in the evidence-based model of Child-Parent Psychotherapy. Additionally, a training curriculum, Keeping Babies and Children in Mind, is available to CSOC partners to support baseline knowledge of this population. Practice consultation capacity for individual youth and families has been developed and a resource compendium is under development.

To assist the workforce in integrating the training into their practice and to help guide cross-system collaboration, CSOC has formed a multi-disciplinary steering committee made up of experts in the field of infant and early childhood mental health, as well as representatives across State agencies, system partners and providers. The committee and smaller targeted work groups will focus on examining how families are connected to appropriate and effective services and how providers and systems engage them in the process. They will examine initial intervention, assessment and planning practices, focusing on how to best support young families during times of crisis or trauma and participate in tailoring of the MRSS practice approach to effectively respond to this population within the existing MRSS structure. Finally, the committee will work to create sustainable cross-system partnerships that will promote enhanced service delivery and better outcomes for families with young children.

The integration of OIHW into CSOC also supports these efforts and helps to ensure that children in placement remain connected to resources and are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions or developmental conditions, and are placed in settings appropriate to their true needs. As part of DCF's strategic plan, CSOC underwent a reorganization and established a stakeholder advisory group that informed efforts towards the promotion of integrated health in primary and behavioral healthcare systems. CSOC's strategic priorities and goals focus on promoting integrated health and behavioral health, building capacity to deliver evidence-based and best practice interventions and services, and enhancing CSOC's capacity to ensure equitable access.

Ensuring Health Care Needs of Youth Aging out of Placement

Since September 2010, it has been DCF's practice that youth aging out of placement receive additional instruction related to their health care needs. This practice requires that youth, as they approach their 18th birthday, are provided with instruction regarding the importance of selecting a health care proxy and are provided with the option to execute such a document, as well as information regarding health insurance and health related resources. The instruction takes place in coordination with development of youth-directed Transition Plans. This instruction augments other state efforts to build life skills competencies with youth as they age into adulthood. Tools developed to assist casework and CHU staff include a tri-fold pamphlet, medical proxy form, revised Transitional Plan for Adolescents, descriptive policy, and an updated health services section of DCF's

Adolescent Services Guide. Ongoing tracking of the practice is done through supervisory review of the transitional and case plans.

CHU nurses also independently engage with youth ages 18-20 with open CP&P cases that are receiving services, whether or not they are in placement. Nurse engagement includes an assessment of the youth's ability to engage and navigate the health care system. CHU nurses provide the youth and young adults with ongoing health education and guidance to improve their ability to independently navigate the healthcare system.

OIHW has administered Medicaid Extension for youth ages 18-21 since 2001, based on the Chafee Act. With the advent of the Federal Health Care Law, effective January 1, 2014, this program was collaboratively adjusted to provide Medicaid for eligible former foster youth through age 26. This program is now known as Medicaid Extension for Young Adults (MEYA). OIHW built on the partnership with DMAHS to increase inter-Departmental capacity to enroll eligible former foster youth into an appropriate Medicaid program once they are no longer involved with CP&P.

NJ FamilyCare, New Jersey's Medicaid program, offers more robust coverage services than MEYA for certain eligible populations, such as pregnant women, individuals with disabilities, and adults without dependent children who need intensive substance use or mental health services. OIHW works with DMAHS to identify former foster youth that may be part of one of these FamilyCare populations and provide education and support for those youth who may benefit from enrollment in a FamilyCare program. Certain FamilyCare programs supersede MEYA enrollment, and OIHW works with DMAHS and CP&P to ensure enrollment for youth is as seamless as possible.

Through these coordinated efforts, the state has continued to consistently achieve 99%-100% compliance with ensuring youth aging out of the child welfare system have access to medical coverage, with the only evident barriers being youth that actively refuse the MEYA service, or youth that remain ineligible.

CHUs continue to train CP&P staff on recognizing pediatric health "red flags," using the enhanced Pediatric Health and Red Flags Tool, which was developed in 2012 and completed in 2014. The final section of the tool, specific to Adolescents, was accepted in April 2014. Training on the adolescent tool was provided in the Summer 2014.

Conclusion

DCF continues to recognize the importance of ensuring that the basic medical and behavioral health care needs of all children are met. The Department recognizes this will require ongoing evaluation to incorporate necessary changes to infrastructure. As part of this process, DCF has already strengthened its infrastructure, which included early changes around case practice and collaboration and more recent changes in areas related to addressing trauma and enhancing service provision. Since the restructuring of DCF's health care delivery system and the release of the Coordinated Health Care Plan, service delivery and physical and behavioral health care outcomes for children in out-of-home placement have improved. The work, partnerships and reorganization outlined in

this plan will continue to inform and drive health care oversight and coordination for DCF.