NEW JERSEY DEPARTMENT OF
CHILDREN AND FAMILIES

2025-2029
Health Care Oversight and Coordination Plan

Introduction. The New Jersey Department of Children and Families' (DCF) Office of Integrated Health & Wellness (OIHW) within the Division of the Children's System of Care (CSOC) 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. DCF's policy manual includes a chapter dedicated to health services for children involved with CP&P.[1]

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 reformed the health care system for children in placement by assessing service gaps, areas of strength, and areas in need of improvement via data collection and analysis, system mapping and best practice review. 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 the Rutgers University François-Xavier Bagnoud School of Nursing (Rutgers School of Nursing) 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.

The COVID-19 public health emergency precipitated the utilization and refinement of contingency and continuity of operations plans (COOP). The COOP allowed for flexibility and new approaches to service delivery that have transformed access to care and prepared DCF for such future events. Below, DCF details the 2025-2029 Health Care Oversight and Coordination Plan.

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 continue to ensure consistent and ongoing quality health care, which supports several priorities of DCF's Strategic Plan.[2]

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

[1] DCF Home (nj.gov); CP&P-V-A-1-100 through -1500.
[2] DCF | Safe, Healthy, Connected: DCF In The 21st Century (nj.gov)

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 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, which stated, "health care management is the responsibility of the child welfare agency, but it is a function that requires medical expertise."[3]

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. 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 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. For performance data related to these measures, see DCF's 2025-2029 CFSP, Section 2, *Assessment of Current Performance in Improving Outcomes, Well-Being Outcome 3.*

Figure 1. Well-child and Preventive Care Best Practice Measures

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

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

Descriptions and 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.[4] 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.[5] 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.

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, gathering and preparing all applicable mental and behavioral health information, and coordinating with necessary parties, e.g., caseworker, resource parent. Through a partnership with the New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS), the state Medicaid agency, community 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.

Mental Health Screenings. 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

[4] The only exception is when a child enters placement from a medical setting. See DCF Policy Manual CPP-V-A-1-1300.pdf (nj.gov)
[5] Ibid.

needs on a continuous basis and to ensure they receive safe and appropriate supports and services.

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 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; repeated every three months or sooner as needed,[7]
- Screening by the physician/health care practitioner conducting the CME, utilizing their identified developmental screening tool, or
- Comprehensive Mental Health Assessment (CMHA) conducted by a licensed psychologist or a doctoral-level clinician (e.g., permit holder, postdoctoral fellow) directly supervised by a licensed psychologist at one of the state's RDTCs.

Since 2016, the Mobile Response and Stabilization Services (MRSS) CP&P Placement Initiative has facilitated stabilization and mitigated trauma for children and youth at time of placement by offering support and education to children and 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. 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 17 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. Current professional development for MRSS and Intensive In-Community Services in practice tailored to infants, toddlers and their families.is in progress which will allow for expansion of this initiative to youth under 3 placed in resource or kin care.

MRSS is also available and delivered to children and youth, regardless of their engagement with CP&P, who are 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

[6] 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.
[7] https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf

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 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.

The MRSS method of engagement and service delivery is in-person. As a result of the COVID-19 pandemic, allowances were made for MRSS service delivery to be made by telehealth. Telehealth guidance that supported this method of service delivery during the pandemic was rescinded at the end of the public health emergency and the expectation of the in-person service delivery standard was re-established. Telehealth service delivery continues to be available only when families request, recognizing families' individual needs, circumstances and perspectives may result in a request for this decision.

CSOC initiated implementation of the Zero Suicide framework with system partners FY23 and FY24. Using the Zero Suicide framework, participants learn how to incorporate best and promising practices into their organizations and processes to improved care and safety for individuals at risk of suicide. CSOC system partners, e.g., CMOs, MRSS, out-of-home treatment programs, and the Family Support Organization, participated in a nine-month Community of Practice to learn and implement the Zero Suicide framework. CSOC continues integrating the principles of Zero Suicide into the system of care through Quarterly Connection meetings.

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 Child Health Program (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.

CHUs complete the Bright Futures Pediatric Symptom Checklist every 3 months or sooner as needed. Positive screen results are discussed with casework staff to guide to appropriate services.

Children entering out-of-home placement can receive a CMHA by a licensed psychologist or a doctoral-level clinician (e.g., permit holder, postdoctoral fellow) directly supervised by a licensed psychologist. The CMHA provides a comprehensive review of a child's total functioning with information and recommendations about the following domains: gross and fine motor skills, cognition, speech and language function, self-help abilities, emotional well-being, coping skills, and relationships to self and others. This service is reimbursable by Medicaid.

Health Care Case Management and Monitoring Follow-Up Care. 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 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.

DCF conducts an annual case record review process for reporting follow-up specific to specialty care needs of children entering placement. The Health Care Case Record Review 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, timely delivery of this information to resource parents, and engagement of parents from whom the child was removed. 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 distinguishes 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.

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 NJSPIRIT data system, DCF's comprehensive child welfare information system. NJSPIRIT includes specific areas in which information related to a child's medical and mental health should be recorded. These electronic windows within NJSPIRIT 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 NJSPIRIT become part of the child welfare case record; pertinent medical documents are uploaded directly into NJSPIRIT.

CHUs utilizes and updates the Health Passport and Placement Assessment form (Health Passport) in NJSPIRIT. 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 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 NJSPIRIT, 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,

- types and results of medical/laboratory testing,
- rehabilitation therapy,
- early intervention services, and
- anticipatory guidance for ages 0-21.

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 managed care organization (MCO) so coverage for and access to required services remains. Communication between and among the CHU, CP&P caseworker, MCO care manager, placement family, and family of origin is encouraged and facilitated through CP&P's case practice model. CHUs continue to train CP&P staff on recognizing pediatric health "red flags," using the enhanced Pediatric Health and Red Flags Tool, updated in 2023.Through the Child and Family Nurse Program (CFNP) CP&P caseworkers have the option to refer in-home families to a Child and Family Nurse (CFN) who can support children and families with identified medical needs in their own homes. The CFN provides nursing consultation and care management on a voluntary basis and is currently available in seven counties.

Psychotropic Medication Policy & Practice and Mental Health Initiatives

Oversight of Prescription Medicines, Including Protocols for the Appropriate Use and Monitoring of Psychotropic Medications. DCF's comprehensive policy concerning the prescription, use and monitoring of psychotropic medication for DCF involved children and any child in CP&P custody ensures that the Department and its partners promote good practice in the interest of better serving children and families.[8] 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. This policy, published in 2017, is in review to be aligned with current best practices and standards.

As a result of OIHW's participation in the Center for Health Care Strategies, Inc.'s Psychotropic Medication Quality Improvement Collaborative project, OIHW established a process for follow-up of individual children and youth identified for review in collaboration with the nursing team. This review includes trend data, compliance, opportunities of improvement, and areas for further study.

CHU nurses maintain information in NJSPIRIT for medications prescribed to children in placement, including psychotropic medication. The information maintained in NJSPIRIT 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. These quarterly 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.

[8] CPP-V-A-1-1500.pdf (nj.gov)

The APN/certified pediatric mental health specialist provides 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 is available for CP&P and CSOC system partners.

Engagement of Community Medical and Non-Medical Professionals and 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 procedures, and serve as liaison between health care providers and CP&P local offices to address emergent issues and concerns.

To enhance mental and behavioral health care within the primary care setting, DCF contracts with hospital systems to operate a collaborative care model by providing education, access to mental health specialists and Child & Adolescent Psychiatrists, and care coordination for patients in the pediatric primary care setting.

Activities with system and community partners are undertaken to enhance awareness and impact of social determinants of health, health equity, positive & adverse childhood experiences, and the impact of such on the lives of New Jersey residents and the health of communities.

DCF Child and Adolescent Psychiatrists. DCF contracts with two full-time Child and Adolescent Psychiatrists 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 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.

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 and neglect have access to medical and mental health evaluations by professionals with specialty training in child abuse, 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 CMHAs for children entering resource placement.

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, law enforcement and child advocacy centers, participate in Multi-Disciplinary (MDT) teams charged with reviewing 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 data and identify areas of need to 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,* adopted as policy in November 2012, 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.

DCF periodically issues a Request for Qualifications (RFQ) for Forensic Evaluation Services by Psychologists in as a means of expanding the existing pool of psychologists that perform forensic mental health examinations. The RFQ is designed to increase the number of resources available to CP&P and to improve upon the quality of psychologists by establishing minimum standards.

From July 2015 to June 2020, DCF contracted with Rutgers University to create DCF's Coordination Center (NJCC) for Child Abuse and Neglect Forensic Evaluation and Treatment to study evaluation quality, disseminate best practices, and advance understanding in the area of child abuse/neglect assessments. The NJCC completed a Quality Improvement Study in 2019 that informs the Department's continuous quality improvement efforts in this area.

Forensic mental health evaluations by the RDTCs Child Abuse and Neglect Psychological Evaluators assist CP&P and the court in assessing whether abuse and/or neglect has occurred, to determine the impact of an event on an individual's psychological functioning, and the level of risk posed to the child.

Procedures and Protocols to Ensure Children in Placement are not Inappropriately Diagnosed. With support from the J.B. and M.K. Pritzker Family Foundation, Advocates for Children in New Jersey (ACNJ) held a series of meetings between July and December 2019 with a team of public and private sector leaders and early childhood experts from across the state. The goal was to develop an action plan to ensure that an additional 25 percent of low-income infants and toddlers in New Jersey have access to high-quality services by 2023, including child care, home visiting, health and mental health services. This work culminated in "Unlocking

Potential," a "vision and action plan to unlock the potential of every child in New Jersey to grow up healthy, safe and educated."[9] The plan includes specific targets for impact and financing across early childhood sectors. DCF was a critical partner in this effort and identified 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:

- optimal infant and early childhood social and emotional development and family well-being,
- a sustainable, statewide, qualified, reflective, and relational multi-disciplinary infant and early childhood workforce as well as collaboration, and
- 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 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 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 were designed to focus on examining how families are connected to appropriate and effective services and how providers and systems engage them in the process. The committee convened multiple times to build relationships, discuss related needs, share information across systems and identify ideas for cross-system collaboration, and identify various barriers and opportunities for positive change in the current systems. As part of its work, the committee identified opportunities for cross-system partnership and collaboration in existing forums in which CSOC could be integrated. CSOC will continue to assess the need for the cross-system forum related to the initiative and convene the committee based on future necessity. The targeted workgroup initially focused on mobile response and practice adaptations for the birth to five population related to mobile response essential functions and how to best support young families during times of crisis or trauma and effectively respond to this population within the existing MRSS structure. The workgroup is currently focused on developing a practice manual that details the MRSS practice with adaptations for providing services to this population, which includes but is not limited to young children in foster care.

[9] Pritzker Children's Initiative - Advocates for Children of New Jersey (acnj.org)

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. 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. Since January 1, 2023, states must now cover youth who have ages out of care at 18-21, regardless of the state in which they lived. These changes are effective for young adults who turn 18 on or after January 1, 2023.

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.

Conclusion

DCF recognizes the importance of ensuring the basic medical and behavioral health care needs of all children are met and to do this requires continuous quality improvement. As part of this process, DCF has strengthened its infrastructure around case practice and collaboration, trauma, and positive and adverse childhood experiences to enhance service provision. The work, partnerships and approaches as outlined in this plan will continue to inform and drive health care oversight and coordination for DCF.