

# A Peek at the DCF Health and Wellness Framework

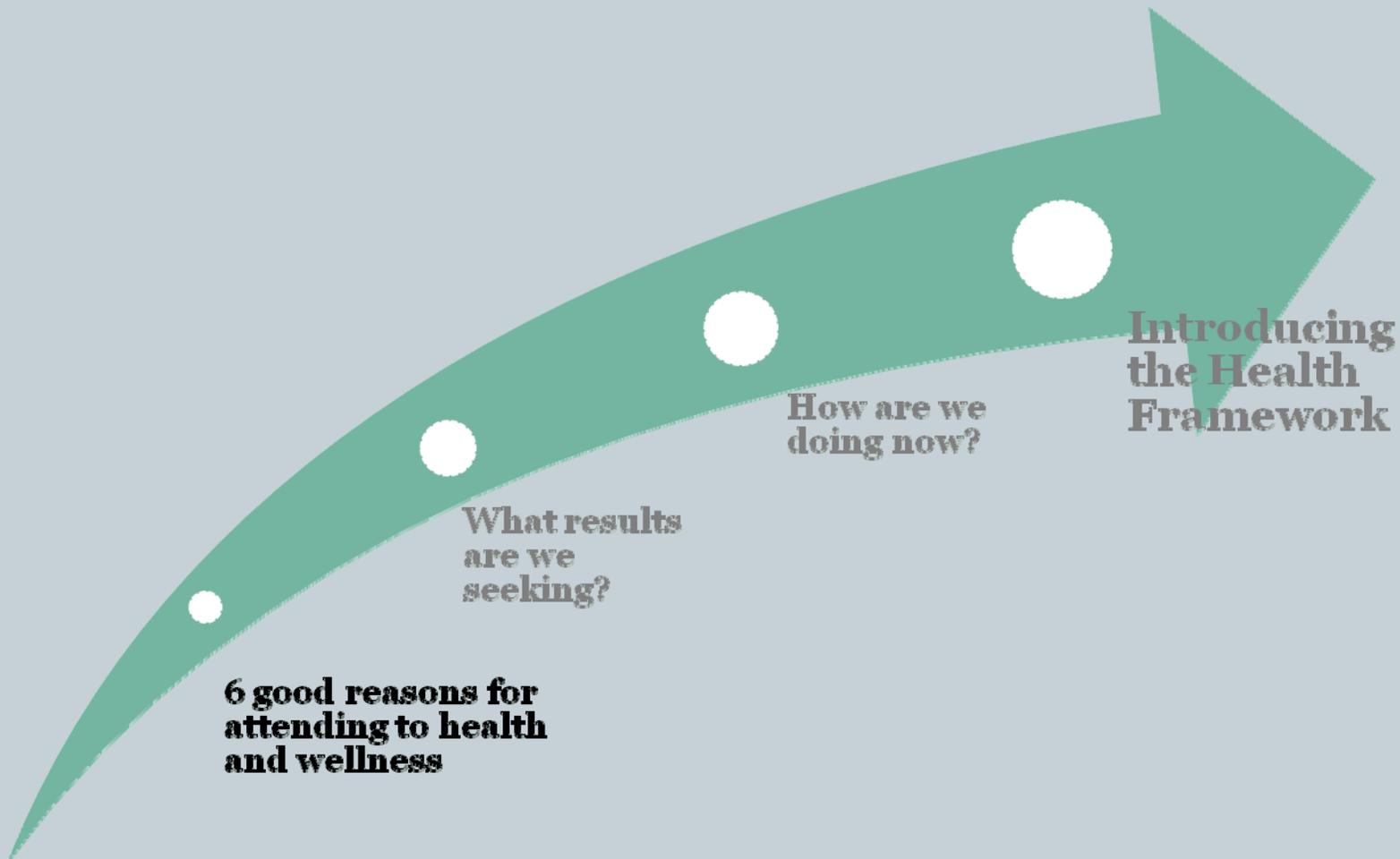


**PRESENTATION TO THE DCF LEADERSHIP  
INSTITUTE**

**January 17, 2013**

# Part I: Six good reasons for attending to health and wellness

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## Reason #1. Health and wellness are at the heart of the DCF Mission...

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*In partnership with families and communities, we will advance the health, safety and learning of the children we serve both in and out of school, identify and support their special talents, and provide opportunities for them to give back to their communities and to leave the Department with an enduring connection to a family.*

## *...and* are fundamental to DCF's Cross-Cutting Themes

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- ❑ Implement strength-based family policy, practice and programs
- ❑ Apply the science of child, adolescent and adult development
- ❑ Expand trauma-informed practice and culture
- ❑ Build new community and agency partnerships
- ❑ Improve leadership, management, supervision and accountability
- ❑ Become a learning organization

# ...and the DCF 2012-15 Strategic Plan: Healthy, Safe, Smart and Strong

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- Manage DCF operations and change (Strat. 8)
- Maximize revenue and develop new investment resources (Strat. 9)

Results-based agency management

Yields more effective services

- Strengthen family-centered practice (Strat. 2)
- Expand regional networks of services (Strat. 3)
- Continue congregate rightsizing (Strat. 4)
- Increase agency and community partnerships (Strat. 6)

To address the needs of children, families & the workforce

- Support public/private workforce (Strat. 7)
- Focus on identified populations of children & families (Strat. 5)
- Increased investment in prevention, health promotion, early intervention and educational success (Strat.1)

And improve child and family well being

- Healthy, safe, smart and strong children and families

## #2. National data reveal that youngsters in foster care face acute and chronic health challenges...

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**Acute Needs:** No fewer than 1 in 4 and as many as 4 in 5 children enter foster care with an *acute* health need.

**Chronic Health Conditions:** Six in 10 have a chronic medical condition, including obesity. One in four in foster care have *three or more* chronic health problems.

**Obesity:** 37% of youngsters in group homes, 28% in kinship care and 21% in traditional foster family care are obese as compared with 17% of children in general. (National Survey of Child and Adolescent Well-Being, 2008):

...and have significant mental health needs

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**Mental Health Challenges:** Between  $\frac{1}{2}$  and  $\frac{3}{4}$  of youngsters entering foster care exhibit behavior or social competence problems requiring mental health care. More than  $\frac{3}{4}$  of youngsters in foster care present with serious emotional disturbance.

**Diagnoses:** By the time they are teenagers, 63% of children in foster care have at least one mental health diagnosis; 23% have 3 or more diagnoses. PTSD, ADHD, MDD, and CD/ODD are most common diagnoses. These children meet diagnostic criteria for these disorders *before* entering foster care.

**Psychotropic Medications:** Nationally, 27% of foster children are prescribed antipsychotics; more than 9 times the rate of those on Medicaid who are not in foster care.

NOTE: Symptoms of trauma are often mistaken for symptoms of mental health disorder.

## #3. Each day, DCF serves and supports thousands of vulnerable Connecticut youngsters...

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- ❑ On any given day, between 25,000 and 30,000 youngsters, are served by DCF directly. This includes committed and non-committed children and is about 4% of the 820,000 youngsters who reside in Connecticut.
- ❑ Among these are about 4,000 youngsters in DCF-funded placements (including family foster care and congregate settings), and this number is declining. Of these, just over 3,100 are committed to the DCF Commissioner and the rest are in Voluntary Services Placements.
- ❑ About 500 youngsters are served each year at the Albert J. Solnit Children's Center and the CT Juvenile Training School.

NOTE: Thousands more children who are NOT on our caseload are served by community agencies funded by DCF, *and* the DCF prevention mandate applies to *all* youngsters in Connecticut.

## ... and we can identify youngsters placed in the foster care system by age and region

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| <b>Region</b> | <b>Birth thru 5</b> | <b>6 thru 11</b> | <b>12 thru 18</b> | <b>Over 18</b> | <b>Total</b> |
|---------------|---------------------|------------------|-------------------|----------------|--------------|
| Region 1      | 121                 | 73               | 236               | 30             | <b>460</b>   |
| Region 2      | 156                 | 80               | 308               | 38             | <b>582</b>   |
| Region 3      | 275                 | 132              | 331               | 42             | <b>780</b>   |
| Region 4      | 344                 | 158              | 438               | 94             | <b>1034</b>  |
| Region 5      | 236                 | 127              | 272               | 38             | <b>673</b>   |
| Region 6      | 149                 | 106              | 244               | 57             | <b>556</b>   |
| <b>total</b>  | <b>1281</b>         | <b>676</b>       | <b>1829</b>       | <b>299*</b>    | <b>4085</b>  |

NOTE: All youngsters in foster care are deemed children with special health care needs. One in 10 has been identified as “medically complex . Of these, 15% have conditions which require intensive support and ongoing care.

## #4. Federal law requires specific health care actions be taken by DCF...

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Fostering Connections to Success and Increasing Adoptions Act (2008)

Develop a plan for the ongoing oversight and coordination of health care services for children in foster care placements including (a) a coordinated strategy to identify and respond to foster children's health care needs and (b) a schedule for initial and follow-up health (including mental health and dental) screening, the monitoring and treatment of identified needs, updating and sharing of medical information, and oversight of medical prescriptions and continuity of care

Child Abuse Prevention and Treatment Act (2010)

Includes automatic referral to the state's IDEA Part C program (in Connecticut, the Birth to Three System) of young children involved in substantiated abuse or neglect cases for whom developmental delay is suspected

Child and Family Services Improvement and Innovation Act (2011)

Includes health equity, electronic health records; links to Systems of Care, protocols for psychotropic medication oversight and monitoring, strategies for meeting mental health needs. Require states to screen for and treat emotional trauma associated with maltreatment and removal; and evidence-based trauma intervention for foster care youngsters

**...and the federal Affordable Care Act (ACA) provides opportunities for better health care service.**

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**Starting on January 1, 2014, former youth in foster care will be able to maintain their existing Medicaid coverage until the age of 26 regardless of their income.**

**ACA includes a provision to support the expansion of early childhood home visitation programs for families at risk including those in the child welfare system.**

**ACA requires that transition plans for youth aging out of foster care include information about health insurance options and identification of a health care proxy.**

**Care coordination and consumer voice are core elements in the ACA.**

## #5. We don't need to invent "best practice." National standards and models of best practice exist.

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### **Some Examples**

*Fostering Health: Health Care for Children and Adolescents in Foster Care* (2<sup>nd</sup> edition: 2005), available from the American Academy of Pediatrics

*Scope and Standards of Excellence for Health Care Services for Children in Out-of-Home Care* (2007), available from the Child Welfare League of America

*Scope and Standards of Practice: American Nurses Association* (2<sup>nd</sup> edition: 2010)

American Academy of Child and Adolescent Psychiatry (AACAP) and Child Welfare League of America (CWLA) *Values and Principles for Mental Health and Substance Abuse Services for Children in Foster Care* (2012), available from the Child Welfare League of America

*A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents* (2012), available from American Academy of Child & Adolescent Psychiatry

## #6. CT Statutes related to prevention and the reduction of child poverty *require* attention to health

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*An Act Concerning Child Poverty and the Use of Psychotropic Medications with Children and Youth in State Care (P.A. 04-238)*

Requires the State to prepare a plan to reduce child poverty by 50% within 10 years. Services and supports include: Vocational training and education; Housing for parents and children; Day care, afterschool & mentoring for children and single parents; Health care access, including mental health and family planning; Treatment, including for substance abuse; Child nutrition

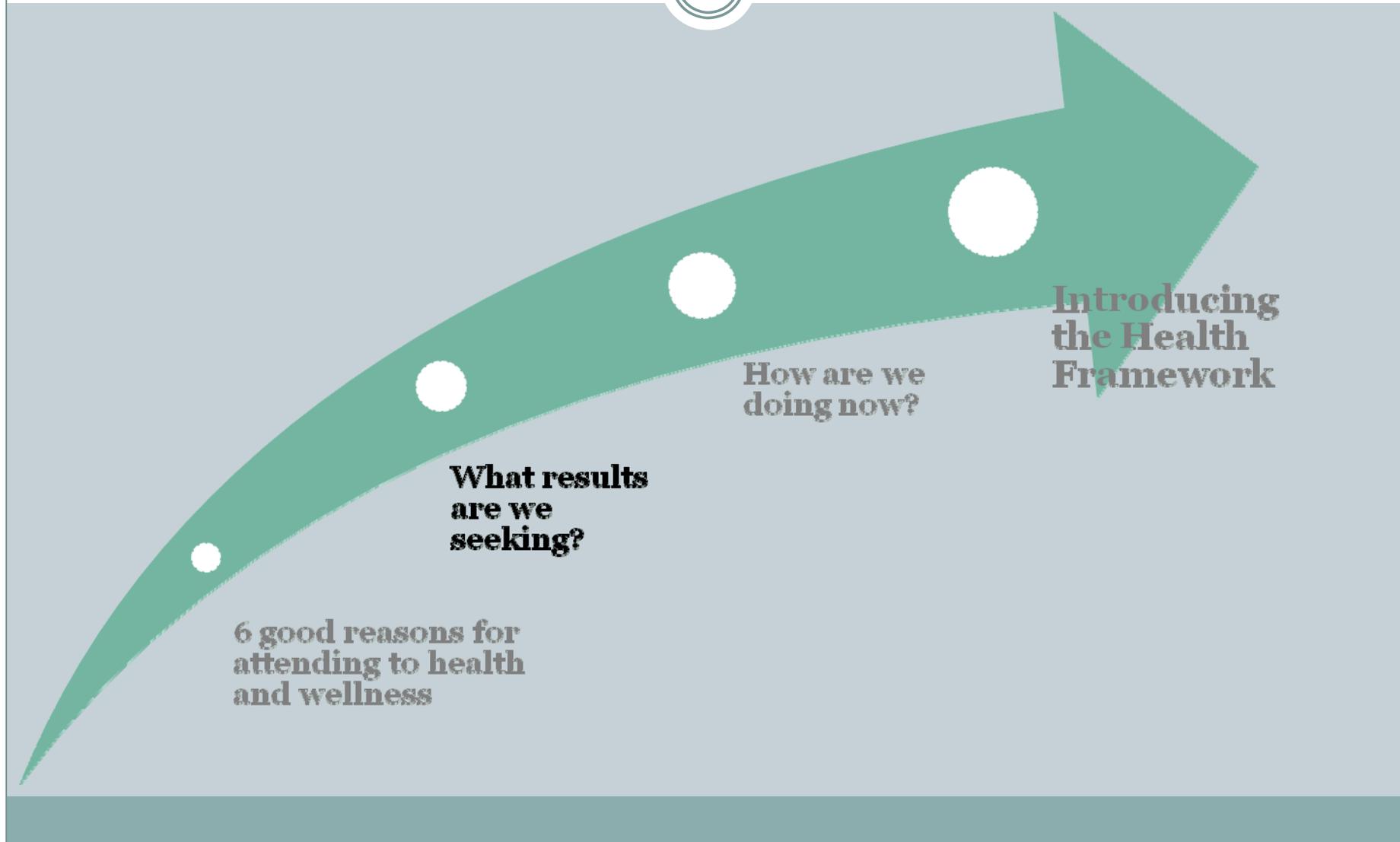
Requires the state to (1) establish guidelines for the use and management of psychotropic medications with children and youth in the care of DCF and (2) Establish and maintain a database to track the use of psychotropic medications with children and youth committed to DCF.

*An Act Concerning State Investment in Prevention (P.A. 06-179)*

By 2020, all state agencies commit at least 10% of their budgets to prevention: i.e., policies and programs that “promote healthy, safe and productive lives and reduce the likelihood of crime, violence, substance abuse, illness, academic failure and other socially destructive behaviors.”

## Part II: What results are we seeking?

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# Health and wellness are a core part of Connecticut's RBA framework

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## **CT RBA Population Results Statement**

*All Connecticut children grow up stable, safe and healthy,  
and ready to lead successful lives.*

## **DCF contribution to the CT Results Statement**

*All children we serve at DCF grow up  
healthy, safe, smart and strong.*

If we are successful, *children* will be...

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## **HEALTHY**

Experience age-appropriate  
cognitive, physical,  
behavioral-emotional, and  
social development

Have a permanent connection  
with a family

## **SAFE**

Experience safety at home, at  
school and in the community

Make positive behavioral and  
life choices

**Optimal  
Health &  
Wellness**

## **SMART**

Achieve educational success

Develop special interests and  
talents

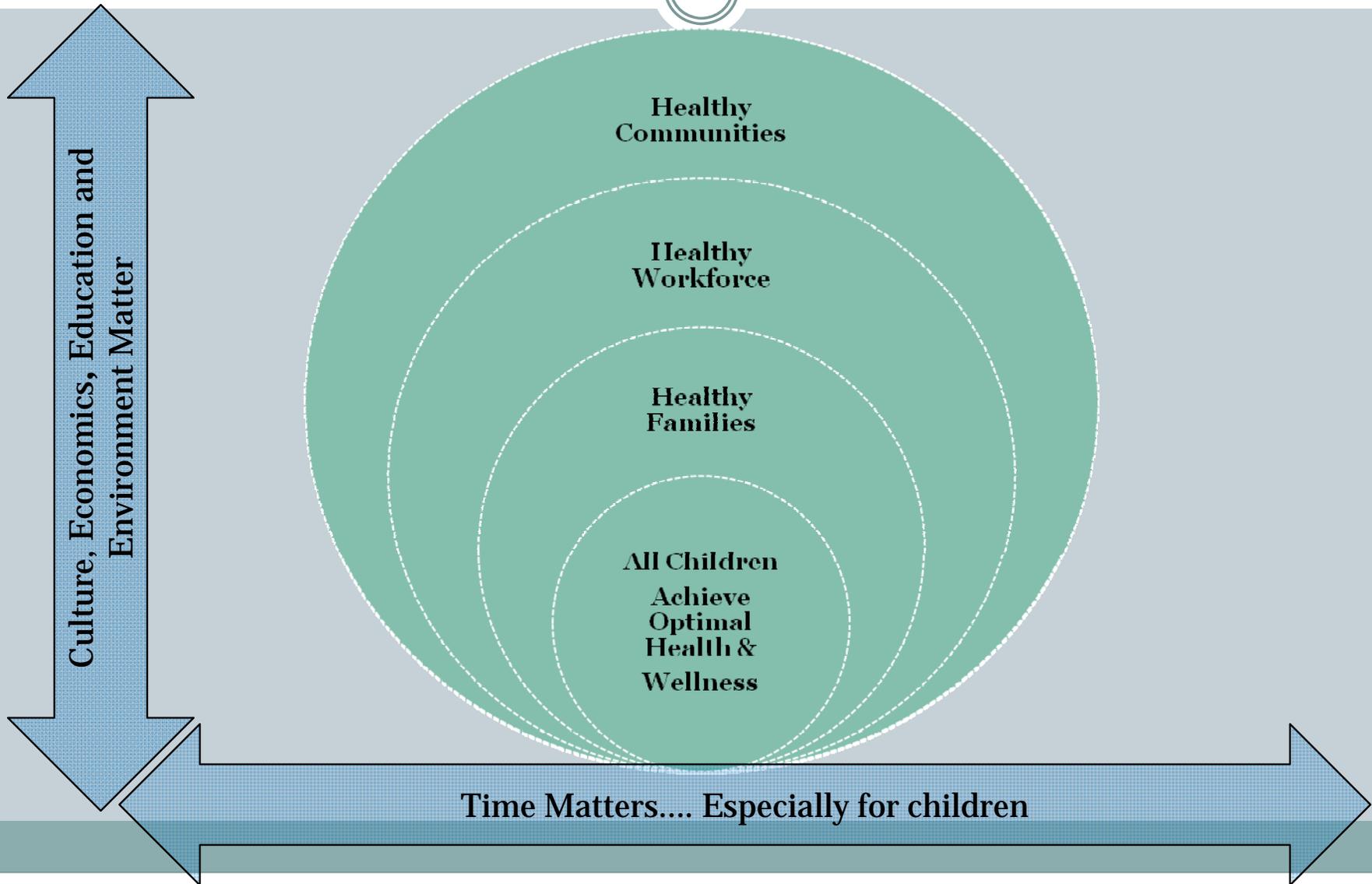
## **STRONG**

Develop internal resilience in  
the face of trauma, adverse  
experiences, and inequity

Connect with protective factors  
in their community

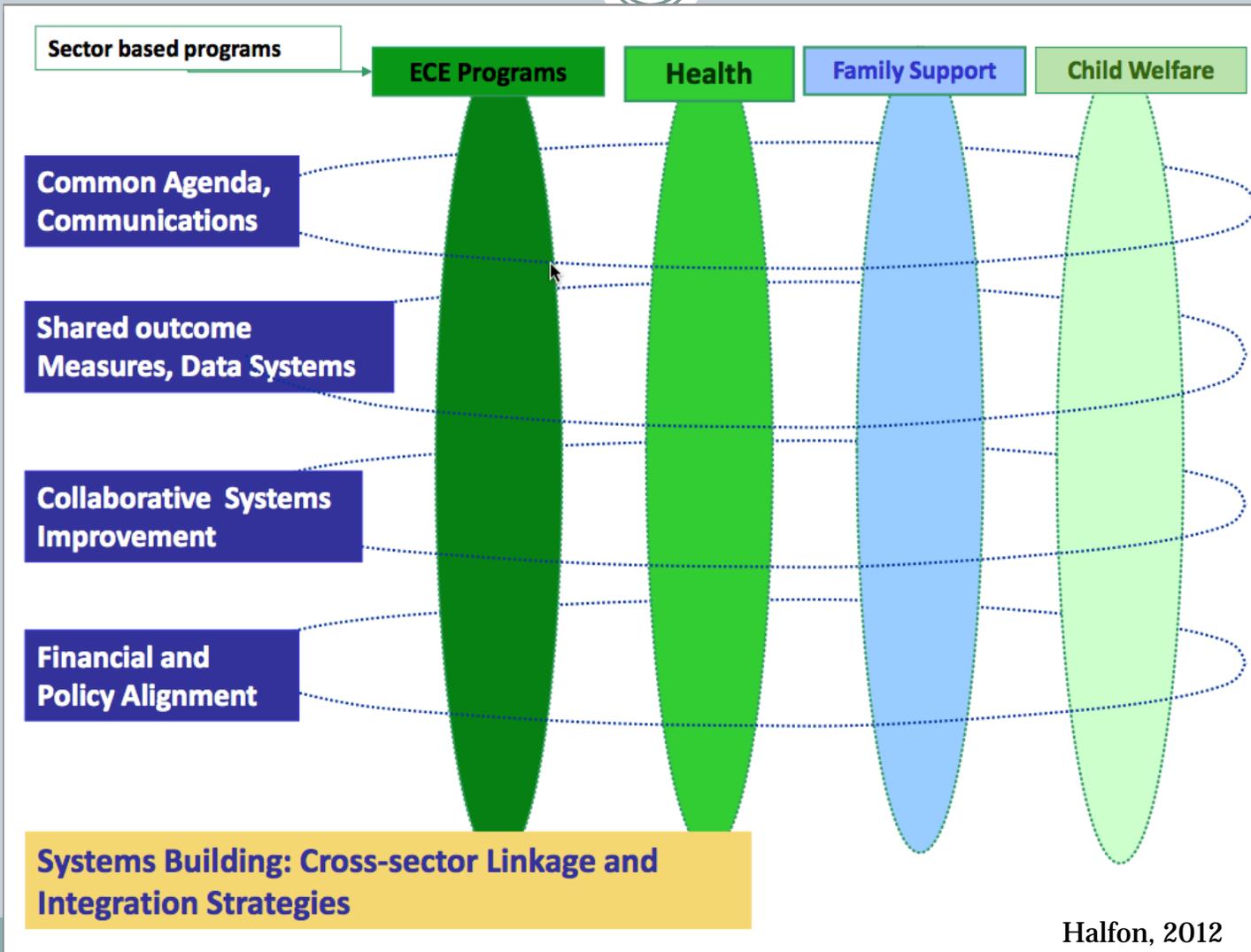
To promote the health and well-being of all children,  
we will need partners *and* to be attentive to context...

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# ....and we will need a “system”

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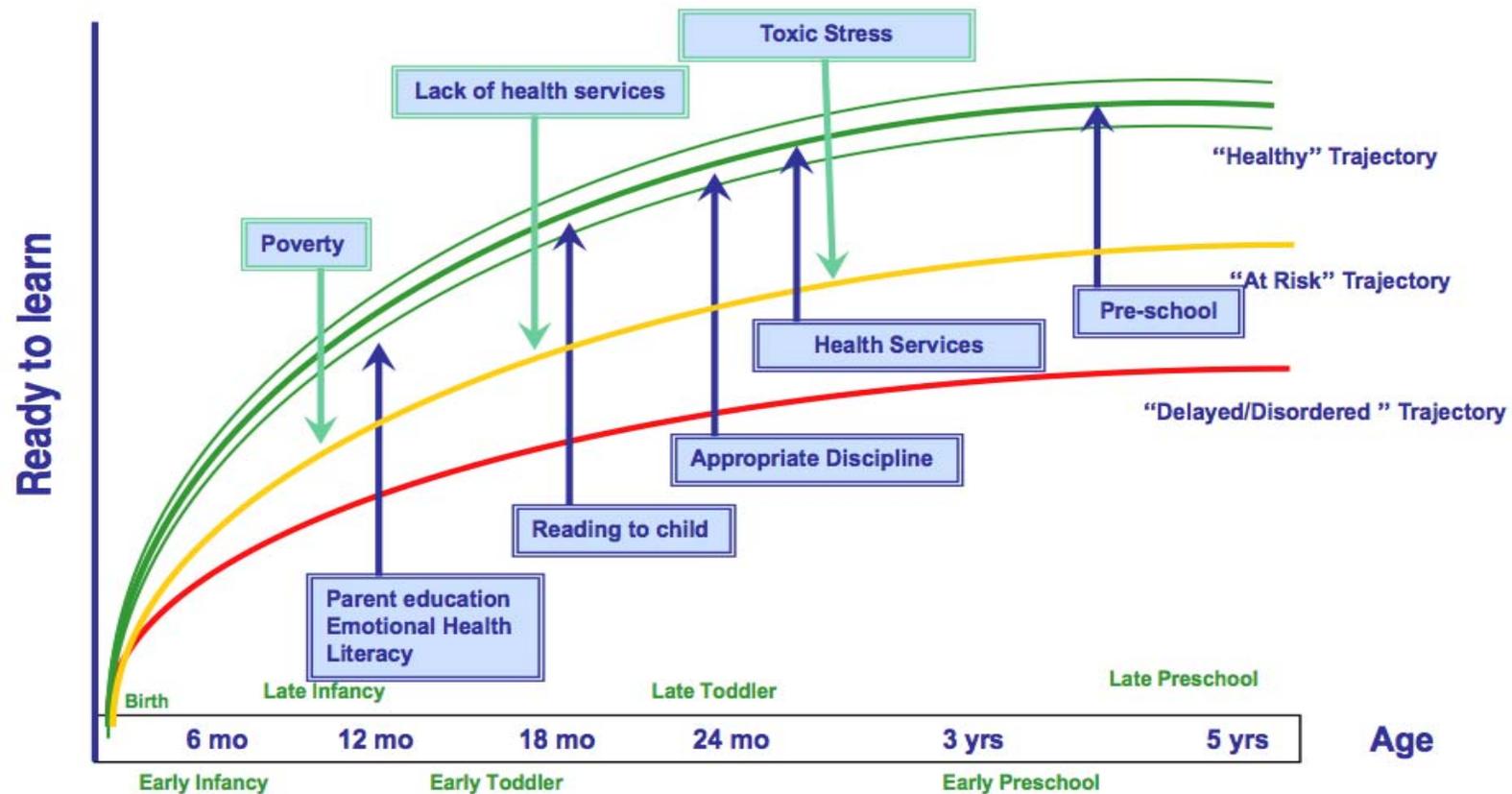


Halfon, 2012

If we want to support children's health and well-being, we will identify, intervene and invest early...

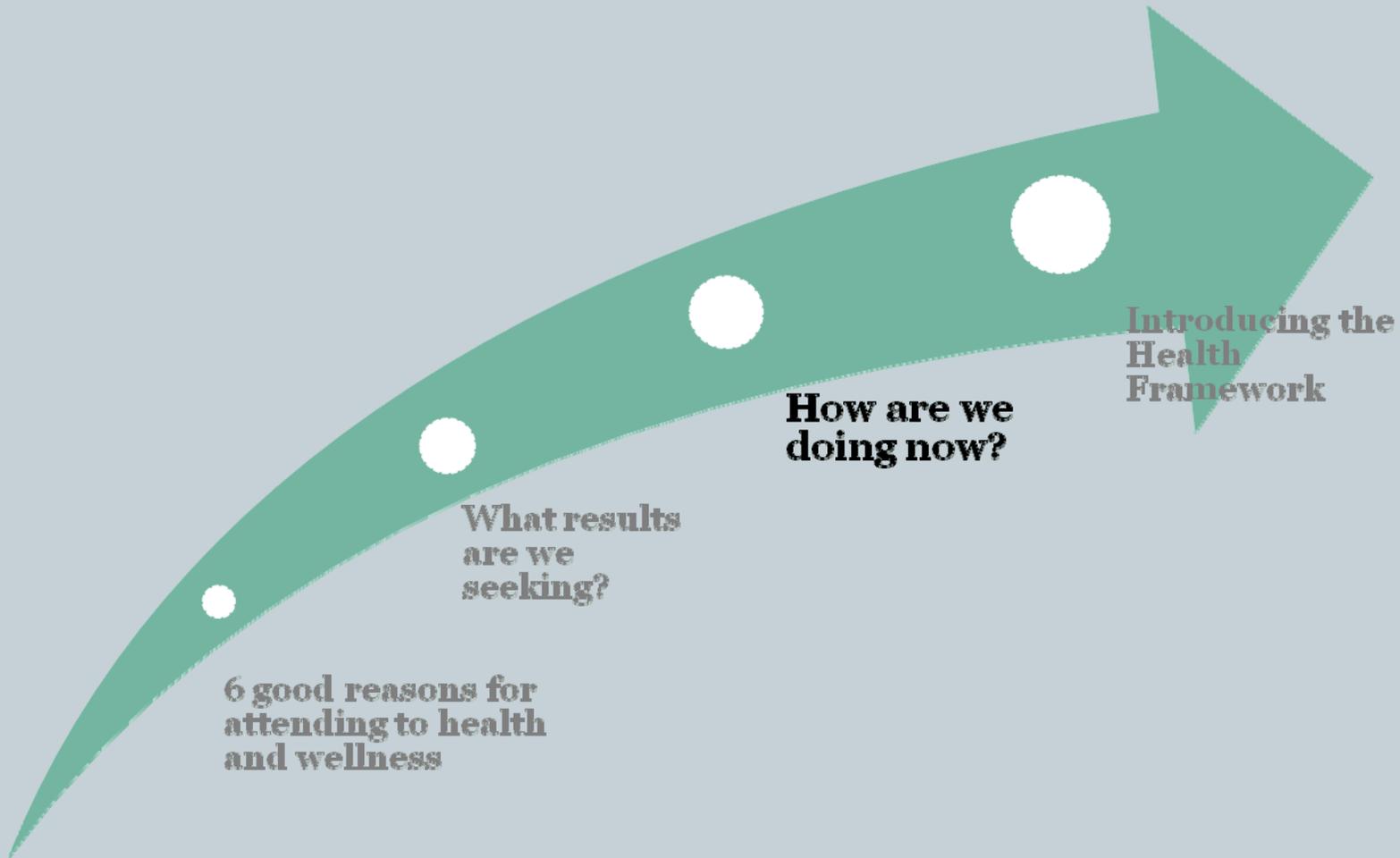
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## Health Development: Reducing Risk and Optimizing Promoting and Protective Factors



# Part III: How are we doing now?

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## *Juan F* measures reveal a mixed picture of service needs met for DCF foster youngsters...

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### Juan F Outcomes Measures (July-September 2012):

- ❑ 94% of cases surveyed for children entering DCF placement received Multi-Disciplinary Evaluations (Outcome #22)
- ❑ 91% had medical needs met (Outcomes #15)
- ❑ 90% had dental needs met (Outcome #15)
- ❑ 72% had mental health, behavioral health and substance abuse service needs met (Outcomes #15)
- ❑ 63% of cases included clinically appropriate, individualized family and children specific treatment plans (Outcome #3)

**Question to be answered: How can we reconcile data for *Juan F* outcomes 15 and 22 with *Juan F* case planning outcome 3 related to children's health and well-being?**

# Other measures reveal challenges as well

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## Dental Needs:

- ❑ Just half (51%) of children in DCF's care received dental services consistent with recommendations for care. This represents a decrease from 56% in 2011 and is no better than national average for children on Medicaid. (Source: CT Dental Health Partnership, 2012)

## Adolescent Well Care

- ❑ Six in ten adolescents (62%) received well care visits consistent with HEDIS measures
- ❑ Immunization rates for adolescents range from 56% to 68% for meningococcal and Tdap/Td vaccines (tetanus vaccines)

# Many youngsters committed to DCF are prescribed psychotropic drugs.

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## Psychotropic Medication:

- ❑ Psychotropic prescriptions declined. In 2010, 25.1% of DCF committed children/youth were prescribed psychotropic medication; decreased to 24.7% in 2011 and 22.8% in 2012
- ❑ In 2012, four in ten (37%) committed adolescents received psychotropic medications as compared 27% ages 6-12 and 2% 0-5 years of age. More males than females received psychotropic medications.

## Some Questions to be answered:

**(1) How does psychotropic medication use compare in more or less restrictive settings in CT? (2) How problematic is polypharmacy in CT for DCF committed children/youth?**

# What is working now?

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**Assessment:** 94% of children entering placement receive a timely Multi-Disciplinary Exam (MDE)

**High risk populations identified:** Including youngsters affected by human trafficking, those with complex medical needs, and children ages birth to three.

**Regional Resource Groups:** In some area offices nurses actively update records in advance of Administrative Case Reviews.

**Restraint & Seclusion:** There has been a dramatic reduction in restraint and seclusion at DCF institutions.

**Reports:** Quarterly Nursing Reports are available for children in private congregate care. Psychotropic medication information on committed children is entered into LINK and is accurate.

## More on what is working...

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- ❑ All children placed by DCF – either as a committed child or through Voluntary Services – are eligible for Medicaid (CT Husky). Exception is children in placement at CJTS or undocumented immigrants who are only eligible for state benefits.
- ❑ Regional Resource Groups exist with nurses in all Area Offices and mental health expertise in most, including clinical social workers and substance abuse specialists.
- ❑ Health advocates and educational consultants, reporting to Central Office, are assigned at the regional level. Additional support is available from Central Office -- including child psychiatry, trauma expertise, pediatrics, nursing and workforce training and development.
- ❑ DCF has access to Value Options (the ASO for mental health services), Connecticut Health Network (the ASO for health), CT Dental Health Partnership (the ASO for dental) and the CT Office of Health Advocacy.

# Our current challenges include...

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## **Meeting Policy and National Standards**

- Variable levels of oversight and monitoring of children with complex medical needs
- Evidence-based psycho-social treatments not available statewide

## **Improving Case practice and Care Coordination**

- Variable completion of Medicaid eligibility paperwork (MA-1) with changes in placement
- MDE recommendations not consistently entered into case plan or followed up

## **Expanding Community-based Systems of Care**

- Inconsistent collaboration with primary care providers/medical home and others
- Lack of knowledge about available resources
- Lack of understanding of medical home & how to ‘assess for “health”’

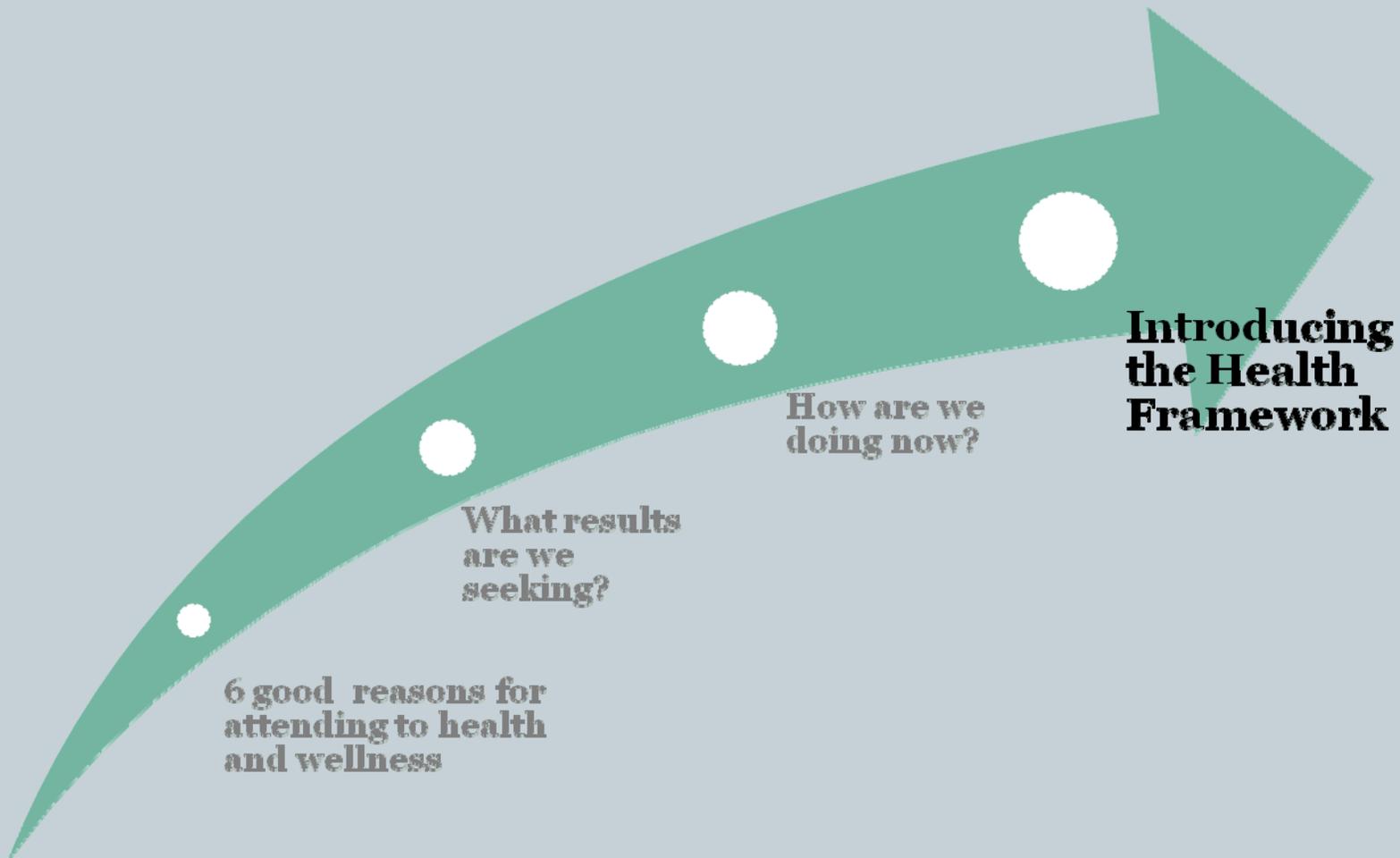
## **Improving technology and medical records**

- Lack of up-to-date accurate and readily accessible medical records for children in our care

## **Addressing Health Inequities**

# Part IV: Introducing the proposed DCF Health and Wellness Framework

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# Introducing the Health Framework

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## Purpose of the Health Framework:

*To guide decision-making and action so that all children engaged with DCF achieve optimal health and wellness*

# Anchoring the Health Framework in Life Course Development Theory...

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## **Four Core Principles of Life Course Theory**

Health is viewed as a complex and evolving process that develops across the life span but can be set into motion years before a child is born.

Health results from the interaction of multiple factors operating nested genetic, biological, behavioral, social and economic contexts which change as a person develops.

Critical and sensitive time periods exist, especially in the first 3 years of life.

Optimal health and wellness results from reducing risk and promoting protective factors.

## ... and Systems of Care Philosophy

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### **The Systems of Care Model**

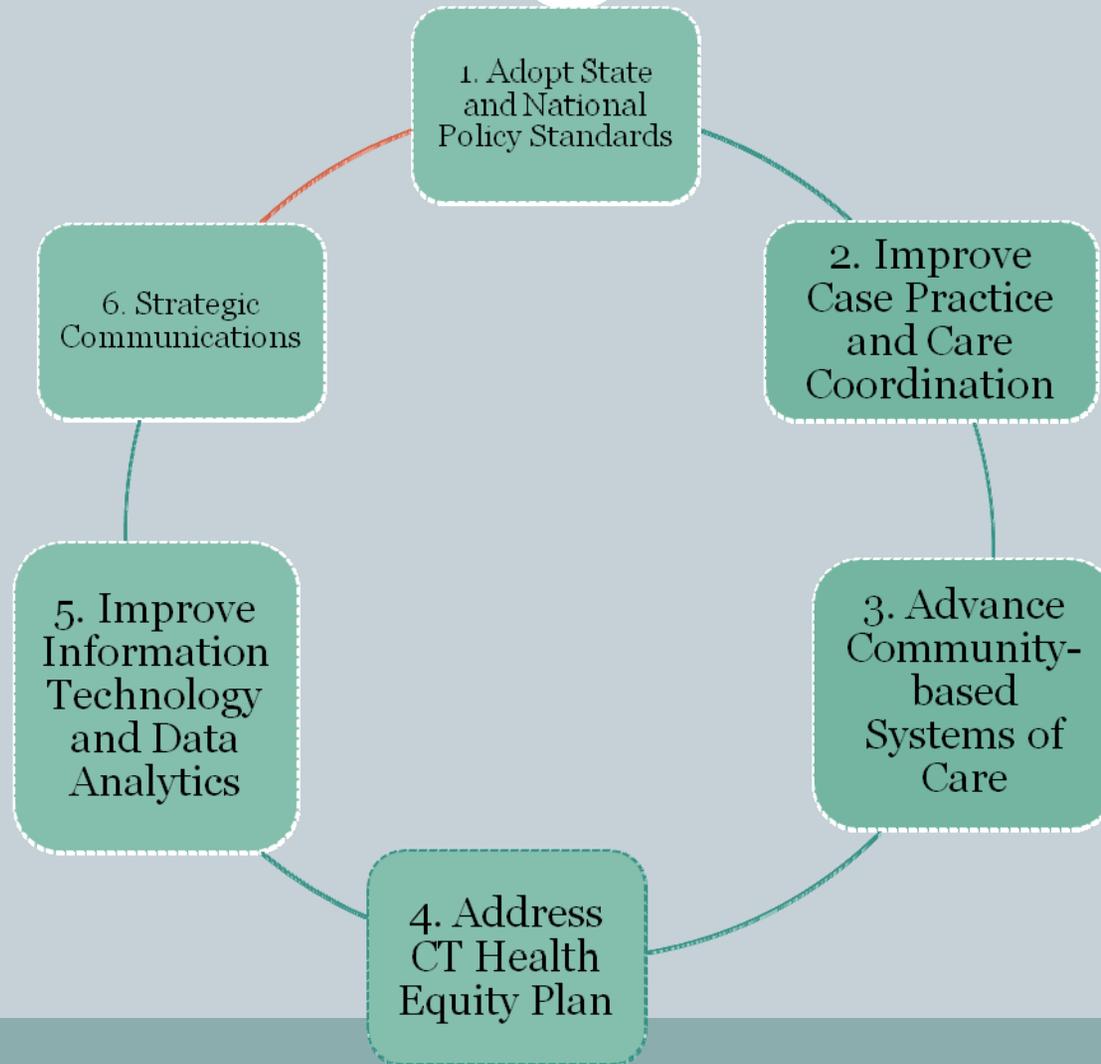
... evolved from the 1975 federal Individuals with Disabilities Education Act (IDEA) aimed at ensuring that children with disabilities have access to free and public education in the least restrictive environment. In the 1980's, it was further defined by the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP).

... is anchored in the following principles:

- Interagency collaboration
- Individualized, strength-based care practices
- Cultural competency
- Community-based services
- Accountability, and
- Full participation of families and youth at all levels of the system.

# 2013 Health Framework: 6 Proposed Strategies

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# Strategy 1 : Adopt State and National Policy Standards

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## **Action Steps in Calendar 2013**

- 1.1 Publish DCF Health Policy package by January 31, 2013  
(see next slide)**
- 1.2 Establish a Health Standards and Practice Advisory Committee as required by Fostering Connections, including CT AAP, CCCAP, DDS, DSS, DPH, DMHAS, DOC**
- 1.3 Align current DCF nursing practice with national standards**

# DCF Health-related policies to be re-issued by January 31, 2012

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## Policies relating to Healthcare

- ❑ Initial Health Screen
- ❑ Multidisciplinary Evaluation (MDE)
- ❑ Routine Care and EPSDT
- ❑ Discharge from care and transitioning
- ❑ Medical Review Board (MRB)
- ❑ Nursing best practice

## Special Populations:

- ❑ Children with Complex Medical Needs
- ❑ Child Abuse Evaluations
- ❑ Obesity Prevention & Intervention
- ❑ Fetal Alcohol Spectrum Disorder (FASD)
- ❑ High Risk Newborns
- ❑ Human Trafficking
- ❑ Specific medical conditions (HIV, etc.)
- ❑ Children in Facilities licensed by DCF

## Strategy 2: Improve Case Practice and Care Coordination

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### **Action Steps in Calendar 2013**

- 2.1 Redefine and strengthen Multi-Disciplinary Evaluation (MDE) to ensure it can inform case planning
- 2.2 Implement agency policy & practice
  - 2.2.1 Health passport
  - 2.2.2 Children with complex medical needs
  - 2.2.3 Obesity prevention and treatment guidelines
  - 2.2.4 Safe sleep environments
  - 2.2.5 Trauma-informed care
  - 2.2.6 Child Abuse recognition
- 2.3 Strengthen the role of medical and nursing personnel in Child and Family Teaming

## Strategy 3: Advance Community-based Systems of Care

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### **Action Steps in Calendar 2013**

- 3.1 Beginning with Region 3, advance the development of regional networks of 'medical home' providers
- 3.2 Participate with the DCF Continuum of Care Partnership to further articulate necessary components of regional networks of care
- 3.3 Work with DCF Academy and the Continuum of Care Partnership to develop and standardize health-related training for DCF workers and community-stakeholders
- 3.4 Work with Central Office and the Solnit Center to increase regional and community access to child psychiatry consultation

## Strategy 4. Address CT Health Equity Plan

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### **Action Steps in Calendar 2013**

- 4.1 Ensure that children in our care reside in lead safe settings
- 4.2 Identify those children in care and custody who are obese and identify actions to reduce their obesity
- 4.3 Identify those children in our care and custody who experience asthma and identify actions to reduce their asthma
- 4.4 Assure children ages birth to three with possible delays for whom abuse or neglect has been substantiated are referred to CT Birth to Three system
- 4.5 Expand attention to issue of teen pregnancy prevention among adolescents in our care and custody and assure proper health, safety and learning among those who are in our care while pregnant

## Strategy 5: Improve Information Technology and Data Analytics

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### **Action Steps in Calendar 2013**

**5.1 With the DCF Office of Information Services and the Office of Research and Evaluation, develop first public data dashboards**

**5.1.1 Characteristics of psychotropic medication use for DCF youngsters served in foster families and congregate settings**

**5.1.2 Number of children obtaining health care consistent with AAP recommendations**

**5.2 With the DCF Office of Information Services, design and advance the use of electronic health records at the Albert J. Solnit Children's Center consistent with State Medicaid initiatives, the federal Affordable Care Act, federal Child and Family Services Improvement and Innovation Act and JCAHO**

**5.3 Continue to strengthen interagency health data development and exchange**

## Strategy 6: Strategic Communications

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### **Action Steps in Calendar 2013**

- 6.1 Disseminate the Health Framework to all DCF operational units
- 6.2 Disseminate the Health Framework to key audiences external to DCF
- 6.3 Develop strategy and mechanisms to provide ongoing updates on progress toward action steps of Health Framework

# How will we measure success?

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## Some current DCF RBA “program performance” measures

### **HEALTHY**

Age-appropriate development  
Healthy weight  
Optimal receipt of health services from prevention through treatment  
Good mental health

### **SAFE**

Child abuse/neglect numbers and rates  
Re-entry numbers and rates  
Parental functioning broadly defined  
Abuse identification by ER medical staff

### **SMART**

Entry to kindergarten readiness  
Reading at “goal” in 3<sup>rd</sup> grade  
Grade level school performance K-12  
On-time high school graduation rate  
Post-secondary training, education or employment

### **STRONG**

School attendance  
Multiple placements or family homelessness  
Parental substance abuse, domestic violence or mental illness  
Parental education level

NOTE: ACYF wellness domains & DCF outcomes are similar.

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## **Cognitive Functioning**

- Language development; academic skills development, school engagement, etc.

## **Physical Health and Development**

- Normative standards for growth and development, BMI (body mass index), etc.

## **Behavioral/Emotional Functioning**

- Self-control, emotional management; internalizing and externalizing behaviors; trauma symptoms

## **Social Functioning**

- Attachment; adaptive behavior, social skills, social competence

# Acronyms

**ACA: Affordable Care Act**

**ACYF: Administration on Children, Youth & Families**

**ADHD: Attention Deficit Hyperactivity Disorder**

**ASO: Administrative Services Organization**

**CCCAP: CT Council Of Child and Adolescent Psychiatry**

**CD/ODD: Conduct Disorder/Oppositional Defiant Disorder**

**CJTS: CT Juvenile Training School**

**CT AAP: CT Chapter American Academy of Pediatrics**

**DDS: Department of Development Services**

**DMHSAS: Department of Mental Health & Substance Abuse Services**

# Acronyms (cont.)

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**DPH: Department of Public Health**

**DOC: Department of Corrections**

**DSS: Department of Social Services**

**EPSDT: Early Periodic Screening Diagnosis and Treatment**

**HEDIS: Healthcare Effectiveness Data and Information Set**

**JCAHO: Joint Commission on Accreditation of Healthcare Organizations**

**MDD: Major Depressive Disorder**

**NCQA: National Committee for Quality Assurance**

**PTSD: Post-traumatic Stress Disorder**

**RBA: Results Based Accountability**