



HEALTHCARE OVERSIGHT AND COORDINATION PLAN

2025-2029

State of Mississippi
Health Care Oversight and Coordination Plan

Section 422(b)(15)(A) of the Act requires states to develop a plan for the ongoing oversight and coordination of health care services for children in foster care. States must develop the plan in coordination with the state title XIX (Medicaid) agency, and in consultation with pediatricians and other experts in health care, and experts in and recipients of child welfare services.

Coordinated Care consists of nurses and treatment navigators who work closely with the specialists and other staff to provide the support and assistance needed to meet the mental, behavioral, and healthcare goals of the youths in care. Through partnership with specialists, families, and the community, nurses advocate ensuring children and youth receive services that promote optimal growth, development, health, and well-being and improve their long-term outcomes. Coordinated Care is staffed with four (4) nurses. Each nurse is assigned service areas to ensure statewide coverage, support, guidance, and education are provided as needed. The nurses oversee the implementation of the State's Health Care Oversight and Coordination Plan. This plan is designed to strengthen activities that improve the well-being, healthcare, and oversight of children and youth in foster care. The MDCPS coordinated care nurses focus on ensuring improved well-being outcomes.

The Health Care Oversight and Coordination Plan has been developed to include all items detailed in the statute at section 422(b)(15)(A)(i)- (viii) of the Act:

Schedule for initial and follow-up health screenings that meet reasonable standards of medical practice

All children in foster care should have access to medical, dental, and psychological care to meet their needs. MDCPS nurses help connect service area specialists to providers that provide medical, dental, and psychological treatment as needed.

EPSDT is Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. Ongoing collaboration with practitioners and medical providers to clarify precise needs for screening/evaluation or services and ensure the provider has the information needed to proceed. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. EPSDT is:

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when risk is identified, and
- **Treatment:** Control, correct or reduce health problems found.

The nurses follow the current timeframes for monitoring and tracking purposes to ensure all youth who enter custody receive the medical, dental and mental health services needed. All youth who enter care must receive an initial medical within 7 days of the custody start date. The purpose of the initial medical screening is to assess immediate health care needs and provide the specialist with health information that informs decisions regarding the needs of the youth. An (EPSDT) or comprehensive medical exam is within 30 days of the custody start date. The EPSDT or comprehensive exam helps identify development, physical, mental, dental, hearing and vision and other screening test and services that are needed for the youth. The youth receive an annual EPSDT or comprehensive exam thereafter. Each youth in care who is 3 years and older receives a dental exam within 90 days of the custody start date. The dental exam is to help ensure dental health for the youth and provide dental restoration, pain and infection relief and maintenance of dental health. A follow up dental exam is completed every 6 months thereafter. A mental health exam is due within 30 days of the custody start date for youth ages 4 and older. The mental health exam is completed to assess for and identify any mental health needs or concerns and helps determine if further services and treatment is needed for the youth.

MDCPS Coordinated Care nurses monitor children entering custody reports daily and provides notification to the specialists of the initial medical, comprehensive, dental and mental health assessments due dates. The nurses follow up with the specialists until the appointments have occurred and are documented for each child that enters care.

How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home

The health care needs of each youth are identified in the initial medical screening, EPSDT/ comprehensive exam or mental health exam. The nurses are responsible for reviewing medical and clinical documentation and working with the MDCPS specialists, foster parents and/ or foster care provider to ensure the appropriate referrals are made to address mental health, medical care, health evaluations or recommended follow up care and services identified from the screening or examination.

The nurses monitor follow-up and responses to the health plan, advocate for children's overall health care needs, coordinate with mental health service providers, intervene and advocate to ensure continuity of care and improved mental and health care outcomes.

How medical information for children in care will be updated and appropriately shared, which may include developing and implementing an electronic health record

The nurses utilize the Centralized Online Reporting Environment (CORE) to pull reports of all youth entering MDCPS custody to assist with ensuring all youth in care receive their medicals, EPSDTs, dental, and mental health assessments, according to MDCPS Policy.

The nurses request hard copies of medical records for youth in care to review and identify any medical concerns, recommendations, and follow-up needs. If there is a recommendation or follow-up indicated, the nurse will follow up with the specialist to discuss a plan to ensure the recommendations and follow-up needed are adhered to.

If medical documentation and information is obtained by the nurse directly from the medical provider, the information is shared with the specialist or supervisor and uploaded to Smartsheet under the youth's name. When the nurse obtains medical information from the specialist, the documents are uploaded to the Smartsheet under the youth's name.

The nurses facilitate monthly well-being cadence meetings to follow up on all youth who have outstanding medical, dental and/or mental health appointments. The cadence meeting allows the nurses to assist in identifying needs, follow up on needs, address concerns and identify barriers.

The Specialists document medical contacts for each youth in their case file following the medical contact template created to ensure all pertinent information is included.

Documentation should include but not limited to the following:

- Date of medical visit
- Provider/Clinic Facility information to include reason for visit (initial screening, EPSDT, dental or mental health exam, follow-up appointment), and name of provider who examined the child
- Vitals (height, weight, temp, blood pressure (B/P), and pulse) as reported by the provider, any pertinent medical history and information discussed for youth, and any treatment, vaccines, and/or immunizations received
- Diagnosis or findings during the appointment
- Medication changes, updates, or prescriptions written
- Recommendation or orders made by a doctor, follow-up appt needs, the specific purpose of the follow-up visit, next scheduled appt with date and time, location youth returned to after the visit, and any medications or prescriptions left with the caretaker
- Indicate if the hard copy is in the case file

Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care

The nursing staff assists with identifying primary care physicians as needed to ensure a medical home is established.

Magnolia Health Plan is still the managed care organization providing services to the state's foster children under the Mississippi Coordinated Assess Network (MSCAN). They assist our specialists in locating medical, dental, and mental health services. Magnolia has approximately 15,000 providers in Mississippi and the surrounding states that are available to provide physical, mental health, and dental services. Magnolia has providers in all 82 counties in Mississippi. MDCPS Coordinated Care team continues to collaborate with Magnolia case managers, medical providers, pediatricians, and

other community stakeholders to ensure all children in foster care gain their needed medical care and services. Magnolia Health Plan has greatly enhanced the state's service array for foster children. They are afforded continuity of having a medical home, opportunities for more specialized services, case management services, and follow-up care.

MDCPS Coordinated Care team reaches out to primary care providers when necessary to identify barriers and work to alleviate any gaps in service delivery to help maintain services for youths and the relationship between MDCPS and the providers.

The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications

MDCPS nurses are utilized for monitoring prescribed medication, including psychotropic medication, and changes to medications. This allows the nurses to be made aware of medications the youths are taking and helps identify and reduce the possible risk of harmful side effects, inappropriate dosing, and medication interactions.

The nurses pull the report from CORE daily to identify youth who have entered custody for the purpose of monitoring and tracking the initial medical, comprehensive/EPSTD, dental, and mental health assessments. Once it has been identified on the report that a youth is in care, the Nurses will begin requesting information and updates regarding medications and medical concerns for each youth. This information will be updated in the Smartsheet under the youth's name and monitored by the nurses.

The nurses provide psychotropic medication consultation and answer questions regarding medications prescribed to the children in foster care.

When psychotropic medications are prescribed or medication changes are needed, the specialist and/or supervisor will request a medication consultation from the nurse. The nurse will then provide a recommendation regarding the medication request that is appropriate for the youth's age, diagnosis, weight, and medications currently being taken. The nurse will also consult with the prescribing physician as needed to address any medication and/or medical concerns.

The nurses shall be notified of medication updates and concerns by the specialist. The nurses will consult with the prescribing physician as needed to gain understanding of medical decisions and then provide education and support to the youths and specialists regarding medical concerns and medications.

The nurses utilize reports from Magnolia Healthcare, such as Foster Care Members report, Psychotropic Medications/Foster Care report, and EPSTD Noncompliance Report. It also provides a list of children by age on psychotropic meds and the medications that have been given. This report is used to aid in identifying where nursing support is needed for the youths in care. It is sent to the nurses via email to review. The nurses also use these reports to determine strengths, weaknesses,

needs and opportunities to assist with securing additional medical services. The nurses discuss identified concern with specialists.

The nurses attend court hearings or submit addendums to court reports as requested or by order, to provide medical information to the judge and GAL regarding medical issues of children in foster care and the correlation between permanent plan and placement.

The nurses collaborate with internal and external partners to provide appropriate procedures in medication management for youth and children in care.

The nurses conduct on-site visits as requested to ensure proper medication administration is observed and that medical access policies are adhered to and aligned with MDCPS policy.

MDCPS Coordinated Care team is working to further strengthen its health care oversight plan by developing a comprehensive plan to address, track and monitor youth who are prescribed psychotropic medications. At this time our nurses are only aware of medication prescribed to youth when informed by the specialists. When the nurses are notified that a youth is on medication, they are able to collaborate with the physician.

How the state actively consult with and involve physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children

The Coordinated Care nurses work and collaborate with pediatricians, physicians, and community providers to maintain the Healthcare Oversight and Coordination Plan.

The Coordinated care nurses serve as liaisons between the specialists, medical professional(s), court authorities, law enforcement, units within MDCPS, and others to coordinate the best care for the youth.

They provide education and guidance to specialists, resource families, providers, and youth. The nursing staff also focus on assisting specialists, foster children, and contract providers to increase access to all resources needed.

The Coordinated Care team collaborates with the Mississippi Division of Medicaid and specialized case management teams within Magnolia Health Plan as needed to ensure the ongoing management of medical, mental, dental, and behavioral health needs of youth in care is met.

The Coordinated care team also works ongoing with Magnolia and other providers to assist them in remaining in contact with the MDCPS specialist as associated with a youth in care to ensure the ongoing support and appropriate services are maintained.

MDCPS Coordinated Care staff attend the annual Magnolia Health Foster Care training and the quarterly foster care meetings to review reports, discuss updates and support that can be provided to the youths to ensure they receive all medical treatment and services needed.

MDCPS has also posted a list of approved EPSDT providers to its internal website for access by specialists to assist with identifying EPSDT providers in their surrounding areas so that that medical examinations, follow-up services and treatment for children in foster care can be scheduled and take place.

The Coordinated Care nurses meet with MDCPS contract providers such as Apelah, Southern Christian Services for Children and Youth, Methodist Children's Home, Canopy, and Hope Village to discuss the role of the nurses and the support that can be provided to the children in their foster homes and group homes.

MDCPS nursing staff provide face to face visits and conduct observation in hospitals and other settings as needed. The nurses answer questions and provide support and guidance related to medication, medication changes, medical equipment and medical care for youth in care.

Nursing staff also meet with foster children as requested to discuss the importance of them taking their medication as prescribed for different diagnosis and medical conditions.

The procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses

MDCPS has a contract with Acentra Health (formerly known as Kepro), who will begin assessing each youth who enters care by using the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment. There is a plan to have this in affect by January 1, 2025. Each youth who enters foster care who reaches the age of 4 while in care are to receive a mental health assessment within thirty (30) calendar days of his/her fourth birthday. At this time all youth who are referred to coordinated care for therapeutic placement are referred to Acentra and assessed using the Child and Adolescent Functional Assessment Scale (CAFAS). This assessment will help to support care planning, decision making on level of care needs, facilitate quality improvement initiatives and allow for monitoring outcomes of services for youths in care. All youth who are identified as medically fragile shall be referred to the coordinated care department for placement and medical needs. The nurse and treatment navigator work together to coordinate medical care, services and placement as needed for the youth.

The nurses document visits and observations with medically fragile children and confirm to the best of their capabilities that each child is receiving optimum care and receiving medical care as needed.

These visits occur when a request is made by the county of responsibility for the nurse to provide support.

A child in care who is identified as medically fragile is to receive follow-up contact/visit by the nurse within Forty-Five (45) days and contact is to be documented in the youth's chart. This documentation should include contact made with the child's specialists regarding medical care received and/ or needed and any follow-up visit that is deemed medically necessary by the coordinated care nurse. A child in care who is identified as having a diagnosis of mental illness, IDD, or behavioral or emotional disorder will receive support from the coordinated care team to ensure that services and supports are in place to meet their needs.

The Coordinated Care nurses collaborate with pediatricians and other community partners to discuss ways to improve medical, dental, and psychological services for children in foster care as well as ways to ensure a continuum of care once reunification or adoption is achieved.

Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document are met

The transition plan shall be developed jointly by the youth, Transition Navigator and Specialist. The plan addresses living arrangements, means of support, education/vocation, food/clothing, transportation and health care. The Transition Plan will be modified as needed each time the youth's family service plan (FSP) is reviewed and updated. Any tasks that need to be completed in accomplishing the transition plan will be added to the tasks and goals under the FSP.

Twelve (12) months prior to the anticipated release of custody date, the specialist, Transition Navigator, youth, and Resource Parent(s) should meet to determine services needed to assist the youth in preparing for his/her independence. During this meeting, the youth will be notified of any health, financial or other benefits that will cease after the case closes.

The Specialist should discuss with the youth a range of living arrangements and engage him/her in an evaluation of the risks and benefits of each option. The Transition Navigator and/or specialist will discuss the availability of affordable healthcare options within the community. Childcare options will be discussed with teen parents.

Youth who are in a licensed foster placement or IV-E eligible are eligible to receive Foster Care Medicaid benefits. If a youth reaches the age of 18 while in care and on Medicaid, they will continue with their full Medicaid benefits until the age of 26, regardless of income, resources, the state they live in, or family size. If the youth is emancipated before their 18th birthday, they will have to apply

for other Medicaid benefits that are based on their eligibility at that time. The Specialist shall inform all youth transitioning out of care if he/she is eligible for Medicaid at the time of their transition out of care. It is the responsibility of the specialist to assist the youth with completing the necessary documents to continue Medicaid services and to ensure he/she has received his/her Medicaid card prior to transitioning out of care. As part of the transition out of care process and for future reference, the Specialist will secure from the youth information on how he/she may be contacted upon leaving custody.

MDCPS shall ensure that each youth transitioning to independence has the following documents and information available to them:

- Adequate living arrangements
- a source of income
- Health care
- Independent living stipends.
- Resource guide necessary to assist youth in locating and enrolling in educational or vocational programs appropriate to their needs, interests, abilities, and goals i.e.; high school or GED programs, colleges or universities, vocational training programs and special education services.
- Supply the youth with a list of community resources suitable to meet the youth's future needs. Ensure that services are provided for the youth to make the transition from foster care to living independently.
- Let the youth know that he/she can contact the Worker when needed. Make sure the youth receives a start-up stipend and any other resource

They shall also be assisted in obtaining or compiling documents necessary for them to function as an adult independently. The documents are as follows:

- An identification card
- Social Security card
- Resume, when work experience can be described
- Driver's license, when the ability to drive is a goal
- An original copy of the youth's birth certificate
- Religious documents and information
- Documentation of immigration, citizenship, or naturalization, when applicable; documentation of tribal eligibility or membership
- Death certificates when parents are deceased
- A life book or compilation of personal history and photographs, as appropriate; a list of known relatives, with relationship addresses, telephone numbers, and permissions for contacting involved parties; previous placement information.
- Educational records, such as high school diploma or general equivalency diploma, and a list of schools attended when age appropriate.

MDCPS will continue to work on improving services, support and guidance provided to youths who are preparing to transition out of care.