Health Care Oversight-Medical

The Division of Children and Family Services (DCFS) policy requires that all necessary medical services be provided to children receiving out-of-home placement services. DCFS is dedicated to ensuring that all foster children receive a full range of health care services, including mental health services. An initial health screen is completed on each child within 24 hours, if the reason for removal is an allegation of severe child maltreatment or evidence of serious injury/illness. All other children receive the screening within 72 hours of removal from the home. All foster children age 3 and above are referred within 5 days for a mental health assessment with the local Community Mental Health Center. DCFS has an agreement with Community Mental Health Centers to provide an intake appointment within 5 days of the initial call by DCFS. Within sixty days (60) from the removal of the home, a comprehensive health assessment is completed on each child. DCFS ensures that all health and mental health services are provided periodically and conducted by qualified providers.

DCFS works with Primary Care Physicians, University of Arkansas Medical Sciences (UAMS) Project for Adolescent and Child Evaluations (PACE) Project and area mental health agencies in meeting the health and well-being of foster children. This work occurs at the individual case level as well as collaboratively in work group settings. In addition, DCFS has increased the health staff around the state and re-established the quarterly training for Health Service Workers.

DCFS works with the medical profession, to ensure that all foster children’s medical and mental health needs are met:

1) Collects sufficient history and medical data from appropriate sources to assess the child and formulate the problem.
2) Ensures that a mental health examination and physical examination is conducted as necessary.
3) Ensures that a diagnosis is established.
4) Refers all children, age 3 and above for a mental health assessment within five days of entering care. Youth are referred to the Child and Adolescence Service System Program (CASSP) or System of Care (SOC) for a wraparound plan, when they require intensive mental health services and inter-agency involvement on service plans. Compliance with the 24-hour & 72-hour health screenings and the comprehensive health screen has improved dramatically in several DCFS areas.

The Division utilizes the periodicity schedule for continued health care assessment and health planning for children in foster care. Each child has a primary care physician that will assess their health need and make referrals as needed to other specialties. Currently, licensing requires placement provider to log and track medication that children in foster care are taking.

The division utilizes a medical passport process that maintains the child health record to ensure that foster parents and other placement providers are aware of the child medical history. The division is exploring the capacity to develop an electronic health record.

“After Hours Resources Line” DCFS has partnered with the Division of Medical Services (DMS/Medicaid), Arkansas Children’s Hospital (ACH) and ANGELS/UAMS to provide an after hour’s call line available for Foster Parent to contact and ask questions related to the medical needs of the children placed in your home. This line is to be used only after hours AND in
situations when the child does not have primary care providers (PCP), the PCP is unknown or family doctor assigned cannot be reached after hours.

DCFS is currently reviewing the functional job description for DCFS Health staff to assure continuity of care for foster children.

Health Oversight-Behavioral Health

The DCFS Behavioral Health unit in Central Office includes prevention services, specialized placements, mental health utilization oversight, System of Care (SOC), and all other issues related to behavioral health concerns within the Child Welfare System. As new initiatives are planned within DHS that will impact services for child welfare clients, the mental health specialist represents DCFS to assure that the needs for children in foster care are a priority. After much work on a 1915B Medicaid Waiver, DHS decided that this initiative would not be pursued. DCFS will continue to be actively involved as other behavioral health initiatives are proposed. The current issue that will impact the mental health system is the result of legislation in 2015 that requires the selection and implementation of a different functional assessment for Medicaid behavioral health recipients. DCFS has shared information with the multi-agency committee tasked with this decision about the CANS (Child and Adolescent Needs and Strength assessment) that our division implemented statewide in February, 2015.

The DCFS Behavioral Health Unit continues to provide child welfare expertise in many multi-agency initiatives and committees, including early childhood mental health initiatives, system of care oversight and other formal and informal committees that may have an impact on the behavioral health system utilized by child welfare. The SOC Director provides an annual outcomes report data on Intensive Family Services (IFS) based on data collected from the NCFAS, (North Carolina Family Assessment Scale). This analysis indicates that many families referred to IFS do not have the level of need that requires this intensive a service. Executive staff are exploring the best response to this information in order to best utilize funds for services that are most effective. Decisions will be made about this service and needed changes implemented in the next fiscal year. Options include having this service provided by DCFS staff, rather than contracted providers. Over the past year, there has been a significant increase in collaboration with DMS on behavioral health issues. A review process has been put into place with DMS, DBHS, DCFS and ValueOptions to review mental health service denials for foster youth. All involved have met with residential behavioral health provider to assist the facility in understanding what trends have been identified related to service denials and what information is needed to adequately convey medical necessity to get approvals for services that our youth require to address health and safety needs. This process will continue with plans to develop additional guidelines for providers that reflect best practices in treatment planning, therefore improving justification for services being approved as medically necessary. This issue was addressed in the annual meeting with acute and residential providers in June 2015 and a plan was developed for data analysis across all providers in SFY 2016 in order to increase consistency in practice to improve outcomes for foster youth related to access to appropriate services.

DCFS continues to receive weekly electronic reports from the Division of Medical Services (DMS) utilization management contractor. These reports identify foster children admitted to inpatient psychiatric facilities, for either acute or residential treatment as well as foster youth who have had approvals or denials for outpatient mental health services. Reports also indicate if
Medicaid has denied requests for continued stays at these facilities. These reports have resulted in increased monitoring and provision of technical assistance to the field regarding more appropriate discharge planning and placement. DCFS Behavioral Health Unit staff send weekly emails to all caseworkers who have a foster child in an acute or residential facility. This email requires information on the status of each child’s plan for discharge placement, DCFS involvement in the treatment process, family involvement, visitation and what the youth is wanting upon discharge. If problems are noted, direction and support is given for field staff. It has been noted that this oversight has resulted in increased quality and quantity of involvement by the assigned case worker, as indicated by provider feedback and documentation of best practices throughout the foster child’s stay in inpatient programs. This oversight will continue with trends being noted in monthly reports. An additional process was put into place in 2015 for one of our larger providers to address continued problems related to communication and discharge planning for acute admissions. The hospital’s admissions coordinator now sends an email to notify the behavioral health unit within 24 hour of admission. The behavioral health unit now sends an email with specific guidance on expectations regarding active participation in treatment decisions, discharge planning and communication with the youth. Positive results have been noted since it was implemented in May, 2015. This process will be expanded to other providers by January 2017, after further analysis of outcomes and procedures are refined.

Community-based Assessments Prior to Hospitalization

The Community Mental Health Centers (CMHC) provide assessments for any foster child in their community to determine if psychiatric hospitalization is necessary and to provide services to divert a hospitalization, if possible. Increased involvement by the community mental health system has resulted in a reduction of institutionalized care with more appropriate evaluations and crisis stabilization services. In 2009, a policy was implemented requiring assessment by the local community mental health center (CMHC) and consultation with central office administrator on-call prior to referring a child under age ten years to a psychiatric hospital. In 2011, the policy was revised to include all foster children, regardless of age. This practice had continued to result in significant number of diversion from institutionalize psychiatric care. SFY 2012 data indicates that 61% of all children assessed by the CMHC’s were diverted from hospitalization. In SFY 2013, 76% of all foster youth assessed for inpatient psychiatric acute care were diverted to community-based service. Data from SFY 2014 indicates that 78% of foster youth referred for assessment for psychiatric care were diverted. July through May, 2015 indicates that 62% of youth assessed were diverted from acute care. These numbers reflect number of assessment and contains some duplication when foster youth have numerous episode requiring assessment for acute care.

Several factors have to be considered in looking at the overall hospitalization rates for foster youth. Youth in most group homes and emergency shelters are assessed by that facility’s mental health professional, not the CMHC. It seems that these youth are being hospitalized at a higher rate. DCFS is currently getting data on the number of youth in group homes and emergency shelters who are discharged from that setting into an acute care facility. A comparative report by facility was shared with those providers in our annual provider meeting in June, 2015. We will continue to explore factors impacting this data. In our annual meeting, providers who have their own full-time therapist indicated that they could provide better crisis intervention to decrease need for acute care.
Foster Home Services by Community Mental Health Centers (CMHC)

In 2011, CMHCs were approached by DCFS to increase services to foster children placed in their catchment areas by assigning therapists to foster homes rather than assigning the next available therapist to a foster child referral. While all CMHCs agreed to attempt this approach, several have excelled in the project and have developed mental health services specific to the needs of the child welfare population. Saline County has a full time therapist assigned to provide services for the foster care provides scheduled and crisis services in the home, at the office, school or any other place that best meets the need of the foster child and foster family. In northwest Arkansas, the CMHC developed an entire service unit for child welfare clients and foster families, in conjunction with their Therapeutic Foster Care program. Assessment services are available immediately and initial appointments are available within less than a week and sooner if the need is urgent. In the spring of 2015, the mental health specialist met with this provider and the DCFS Area Director to work toward integrated treatment planning to insure that the mental health treatment plan reflects goals consistent with DCFS case plan permanency goals.

In other areas, planning for specialized foster care services is impacted by workforce issues are a constant barrier in development of new services. DCFS is involved in ongoing planning process with the CMHC that covers most of Area 3, to replicate the service array and approach that was implemented by the CMHC for Area 1 in northwest Arkansas. Quarterly meetings have been scheduled with the CMHC management staff and DCFS management staff to plan and implement specialized service for foster children in that area. As opportunities arise, more specialized programs by CMHCs will be encouraged through continued consultation and increased sharing of data that could impact fiscal viability of these programs.

Oversight of Psychotropic Medication Utilization by Foster Children:

Psychotropic Medication Plan Elements

1. **Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children’s mental health and trauma-treatment needs (including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication).**
   The PACE evaluation now includes a trauma screening component. Continued monitoring activities will determine when or if the current process and screening tools utilized should be revised or augmented with other trauma assessments. As part of the IV-E Waiver, the Child and Adolescent Needs and Strengths assessment (CANS) was implemented statewide in February, 2015. The Arkansas version of the CANS contains multiple items specific to trauma which will enable DCFS staff to more quickly determine specific trauma services necessary to meet the needs of our clients. Matching client services needs with therapists who have been certified in Trauma-Focused, Cognitive Behavioral Therapy (TF-CBT) will be a focus in the next few years. The Psychiatric Research Institute at the University of Arkansas for Medical Sciences has trained and certified more than 300 therapists across the state. DCFS will access those therapists when the CANS functional assessment indicates that trauma services are needed. Development of specific referral procedures and information dissemination will occur in SFY 2016. Ongoing monitoring will occur. Ongoing monitoring is required to
determine when or if changes need to be made in the trauma instruments utilized within the PACE.
As indicated above, per policy, all children who are age three and older are referred for a mental health assessment within five days of entering care. This practice addresses the need for early assessment and intervention to determine what services are necessary, including evaluation of psychotropic medication needs. If the assessment indicates need for continued treatment, the CMHC is required by Medicaid to have their psychiatrist evaluate that client within 45 days.

2. **Informed and shared decision-making and methods for on-going communication between the prescriber, the child, his/her caregivers, other healthcare providers, child welfare worker.**

General Medication Administration Log is required, which includes psychotropic medications.
Implementation of specific form for Administration and Monitoring of Psychotropic Medications is a strategy to increase effective monitoring. A draft form was developed through collaboration with DBHS Medical Director and other Child Psychiatrists. Implementation has been delayed due to provider feedback that the form does not meet all requirements of national accreditation agencies. Therefore, this task will need further investigation to determine when or if this is the most appropriate approach.

A guide was developed by DCFS for case workers and foster parents to assist them in asking pertinent questions regarding target symptoms, potential side effects and alternative approaches to address current problematic behavioral health issues. The guide was developed in collaboration with the Division of Behavioral Health Services. This guide has been distributed in meetings, foster parent newsletter and in response to individual case needs. DCFS will make this information available through the website for foster parents.

3. **Effective medication monitoring at client and agency level.**

**Client specific monitoring:**
Foster parents or other caregivers along with FSW monitor for compliance and outcomes. Please see #2 for additional information that is directly related to effective monitoring as well as shared decision-making.

Whenever the prior authorization process or concern from DCFS staff or other stakeholders identifies a foster youth as having a questionable medication regimen, a review process has been established. The chief psychiatrist reviews the medication and history, providing recommendations for any action that might be required.

**Agency/systemic monitoring:**
Medicaid, DBHS and the UAMS Department of Pharmacy currently monitor psychotropic medication utilization. Flags have been set to screen out prescriptions for children that are outside specific, best-practice guidelines. DBHS psychiatrist alert DCFS Mental Health Specialist before overriding the flag to allow the prescription for
foster children. Information is available on trends and outcomes for general population but not readily available specifically regarding foster children.

Medicaid pharmacy reports on psychotropic medication utilization by foster youth are reviewed quarterly for trends or issues that may need intervention for foster youth as a whole or case-specific. This report also contains comparative data on utilization rates of non-foster youth to determine if any practice disparities are occurring for the child welfare population. Beginning in January 2013, Medicaid began providing reports containing the following data for the previous 3 month time period:

# foster children on any psychotropic medication
# foster children on antipsychotic medications
# foster children on stimulant medications
# foster children on 5 or more psychotropic medications
# foster children on a combination of Clonidine and Guanfacine

Additional data was added in 2014 to include information related to whether those children also have received other behavioral health services. The purpose is to explore whether systemic requirements are needed to insure that other psychosocial interventions are being utilized, rather than just medication to treat behavioral health symptoms. Each report is broken out by ages – under age 6, ages 7 to 13 and ages 13 to 18. This data is reviewed quarterly and action plans initiated, as deemed necessary to improve the care of children in foster care. Report content will be revised according to findings and need to monitor other aspects of medication utilization. Additional data reports will be requested on an ongoing basis as issues of concern are noted from a system or client-specific perspective.

Medicaid implemented the requirement of informed consent and metabolic profiles for all Medicaid recipients, including children in foster care for the prior authorization process for antipsychotic medications. This went into effect in June 2012 for all youth with Medicaid.

Reports are reviewed quarterly, indicating that there have not been variances in trends when comparing foster youth and the general Medicaid population. Trends indicate that whenever increased monitoring or justification by physicians is required, then prescribing practices decrease for those medications.

This review process will be ongoing with continue collaboration with Medicaid regarding changes needed to effectively insure best practices in psychotropic medication management.

4. Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible Child and Adolescent Psychiatrist (agency and individual case level).

DCFS is works closely with DMS on psychotropic medications issues, both systemic and child-specific, when issues are identified in medication practices involving a foster child. DBHS Medical Director and Board Certified Child Psychiatrists with the Arkansas State Hospital and DCFS have a strong, collaborative relationship that includes involvement in
our DHS Inter-Divisional staffings for Complex Cases and consultation on client-specific medication issues that arise and system-wide planning.

DCFS continues to utilize a child psychiatrist through the Arkansas Division of Behavioral Health Services (DBHS) for case-specific consultation on complex behavioral health issues and psychotropic medication. The Chief Psychiatrist for the Division of Medical Services (DMS) has increased his involvement regarding the child welfare population in the past year. He is an active participant in Interdivisional staffings, held three to four times monthly on youth with complex issues. He intervenes on some cases, if appropriate, when services have been denied by the utilization review contractor for Medicaid and when medication prescribed appears to be questionable.

This consultation with DBHS and DMS continues to result in case specific interventions such as obtaining second opinions and decreasing or eliminating psychotropic medication in young children. An example of this collaboration on medication issues is a case reviewed in Interdivisional staffing of a foster youth on multiple, high doses of psychotropic medications and negative side effects were a major concern. A plan was immediately implemented with the child psychiatrist oversight of a complete medication wash, with a special safety plan in place to insure safety for the youth and others during this process. DCFS, DBHS and DMS will continue and strengthen this practice through informal and formal consultation, sharing data and determining appropriate interventions.

Medicaid now allows for medication management for the under-age 21 through telemedicine to be billed. This policy change will enable increased numbers of foster children to receive medication management by the most qualified physicians.

At this time, there has not been a process set up for a child psychiatrist to treat or review each foster child’s medications due to workforce and other initiative being implemented to transform behavioral health in Arkansas. The Medicaid review and monitoring by the mental health specialist is meeting the needs for those children for whom concerns have been identified related psychotropic medication utilization.

5. **Mechanisms for accessing and sharing accurate and up-to-date information and educational materials related to mental health and trauma-related interventions to clinicians, child welfare staff and consumers.**

DCFS worked with UAMS Dept. of Psychiatry and the Partnership to develop and implement training for DCFS staff on trauma informed practices. All Management, supervisors and FSWs have been trained. Trauma-informed care has been integrated in new worker training.

While progress has been made to implement data sharing between Medicaid and DCFS, additional mechanisms are needed to have a full cross-system strategy for sharing data and utilizing that information to impact service delivery.

Annual meetings have been implemented with each contracted service provider type, including emergency shelters, group homes, residential providers, counseling, substance abuse, acute and psychiatric residential and intensive family services. In June, 2015, each of these meetings included a section on trauma informed care and expectations for the increased utilization of evidence-based trauma services. Providers were given information on where and how to obtain training and expertise in trauma. They were also
informed that trauma expertise would be addressed in contract performance indicators by the next state fiscal year. This expectation will include all levels of staff involved in the care of foster youth, not just licensed, clinical staff. All providers were cooperative and supportive of ensuring that his approach would become standard practice. Quarterly conference call with each provider type will begin during SFY 2016 for continued follow-up on these issues. DCFS is also gathering information on all current provider practices related to trauma-informed care to assist in a developing consistent expertise across provider types.