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# Draft Report on Psychotropic Medications For Foster Children

by the DHS Medication Management Workgroup

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## **Executive Summary**

The primary goals of these recommendations are to ensure the safety of foster children on medications, to improve the overall quality of their mental health care and to enhance health and mental health outcomes.

The Medication Management Workgroup is concerned that DHS has custodial responsibilities for these vulnerable children that may not be met with current staffing and procedures. Additional resources will be needed to implement many of these recommended actions.

Because psychopharmacology should be only one part of a comprehensive behavioral support approach for children with complex needs, solutions to these concerns should not be limited to addressing psychotropic medication practices alone, but should be integrated with improving mental health and related services. The development of specific solutions to these concerns must include initial and ongoing input from all relevant stakeholders who provide direct services to foster children. Solutions must be aligned and integrated with other state system-of-care initiatives.

Specific Recommendations:

- Develop health-related expertise regionally to provide technical assistance to local case workers for complex medication issues, behavioral issues, and other related mental health and physical health concerns. This would probably involve increased Child Welfare staffing on a regional basis.
- Develop specialized case management services that would have a smaller case load of children with extremely complex conditions. These workers would need specialized training and access to ongoing supports.
- Increase availability of mental health services so that high quality wraparound services are available to foster children with complex needs, and so that all foster children can receive the standard mental health assessment within the currently required timeframe.

DRAFT

# DRAFT

- Hire or contract with a physician to serve at least part-time as Medical Director for CAF Child Welfare.
- Establish a CAF Child Welfare Advisory Committee to provide the next phase of strategic planning; to provide the specific framework and details for these recommendations; and to assure ongoing integration of psychotropic medications within the system of care for foster children.
- Issues that the Advisory Committee will need to address further include:
  1. Psychotropic prescribing guidelines as thresholds for case review;
  2. regional oversight structure and staffing needs;
  3. the informed consent decision-making process; and
  4. accountability within Child Welfare for implementing required procedures and broader quality improvement processes.
- Establish a Behavioral Health Review Team for the foster care program to review cases that fall outside the established prescribing guidelines. The review process would address the comprehensive plan of care.
- The Advisory Committee and Behavioral Health Review Team would include family and youth voice and cultural competency strategies.
- Develop policies and procedures to ensure that, at a level of psychotropic medication determined by the CAF Child Welfare Advisory Committee, every child in foster care has a comprehensive plan of care, a comprehensive mental health assessment and consultation by a child and adolescent psychiatrist.
- Develop data system capability in CAF and DMAP to better track psychotropic medication use for children in DHS custody, and to provide constructive feedback to prescribers and other stakeholders.
- Develop workforce and training capacity in Child Welfare for both psychotropic medication management and the wraparound planning process. Such training should be made available to foster (and birth) parents and providers.

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- Sponsor pilot projects examining different models to improve quality of care and linkage of services, especially between psychotropic medication prescribers and other components of the system of care.

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## **DHS Medication Management Work Group Summary of Contextual and Informed Consent Issues**

### **Contextual (Non-Medication) Issues**

1. Inadequate access to appropriate mental health services
  - a. This is a problem across the nation.
  - b. Rate of OAR-mandated mental health (MH) assessment within 60 days for children over 3 is 31 percent. Possible reasons:
    - i. Foster parents and / or caseworkers don't know how to access MH
    - ii. MH system not adequately responsive.
    - iii. Foster parents delay taking child in until specific need arises; or they may think this rule is optional.
    - iv. Caseworkers are overburdened and can't attend to this in a timely way, thus leaving it to foster parents.
    - v. Bias against mental health services may influence foster parents not to pursue; this may also be influenced by cultural attitudes.
    - vi. Foster parents may be reluctant to have diagnosis or behavioral assessment change that would influence their monthly rate.
    - vii. Foster parents prefer to go to provider they already have an established relationship with such as primary care provider (PCP).
    - viii. if physician (PCP or psychiatrist) is consulted first prescribing may be viewed as the most accessible, quickest way to stabilize the child. At the moment of prescribing both parties feel something is being done.
    - ix. Linkages between PCPs and MH system are very poor. Barriers exists to access and PCPs may be unclear how to access or skeptical about availability of needed services.
    - x. Barriers to getting appointments: long wait lists, eligibility criteria not met if no problem reported, etc.
2. Continuity issues
  - a. Frequent moves prevent child from getting established with mental health provider.

DRAFT

# DRAFT

- b. Lack of historical information about the child’s developmental and mental health history.
  - c. Fragmentation of system: no centralized data; need for children placed in foster care to have more effective tracking/monitoring over time of MH status.
  - d. Poor communication: providers don’t talk to each other enough (e.g., PCP to MH, psychiatrist to psychiatrist, etc.)
  - e. Role of MHO payment mechanisms: Carve out results in fragmentation between drugs and MH services, works against collaboration.
3. Workforce and knowledge issues
- a. Caseworkers:
    - i. Serve as the primary case managers but are not educated about mental health needs and what services are appropriate.
    - ii. Not prepared for role of case manager for child with serious MH needs: caseloads too high and not specifically trained in wraparound process.
    - iii. They do not have control over entry to other services (MHO does).
    - iv. Tend not to be proactive because of burden of professional role (e.g. high case load, busy ‘putting out fires’).
  - b. Foster parents
    - i. Have limited education/information about MH issues.
    - ii. Not prepared for child with serious emotional/behavioral disorder.
  - c. Limited foster care resources resulting in some homes having too many foster children.
4. Roles and incentives of participants that may predispose toward prescribing
- a. Inadequate foster care placements and supportive services
    - i. Caseworkers are motivated to maintain placement even if not psychologically optimal for child because of inadequate placement alternatives.
    - ii. Importance of right placement – sometimes with better placement, a psychiatric diagnosis can “disappear.”
    - iii. Number of children allowed in foster homes too high.

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# DRAFT

- iv. Lack of support: foster parents do not have access, especially timely access, to behavioral support intervention (especially in-home behavioral support services) or respite.
- v. Need for comprehensive crisis plans to avert unnecessary placement disruptions.
- b. Attitudinal issues
  - i. Concern about child's manageability/stability and child's effect on family life can influence all participants toward finding quick solutions.
  - ii. In foster homes with many children, behavior control is higher priority because behavior problems of one child can destabilize other vulnerable children.
  - iii. Foster parents possibly less willing to accommodate child's disability than long-term parent who has learned how to make effective accommodations.
  - iv. Foster parents may have limited time, energy, motivation to invest in more time-consuming psychosocial alternatives.
  - v. Prescribers are motivated to deal with crises as quickly as possible and to provide solutions. If the prescriber is not familiar with mental health system the provider is likely to use medications, the tools s/he possesses.
  - vi. General attitudes about psychotropic medication have become more positive with increased marketing, greater social acceptance and some positive efficacy studies. There are few long-term outcome safety studies of some medication classes; also there is scant data on use of multiple psychopharmacologic agents.
- c. Informational issues
  - i. All participants lack longitudinal experience with child and thus have limited information about what other strategies could help the child adapt.
  - ii. Lack of general knowledge about trauma-informed care, identification of neurodevelopmental issues, psychological impact of separation from birth parents, behavioral sleep strategies and other behavioral support approaches, etc.
  - iii. Foster parent and caseworker have limited understanding of child's psychological status, including internal motivations, fears, worries, wishes. This may results in

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# DRAFT

unbalanced focus on behavior rather than psychological needs and lead to greater acceptance of medical rather than psychosocial alternatives.

- d. Systemic issues
  - i. Prescribers working in acute settings such as hospitals and residential treatment are under pressure to start treatment as soon as possible and not use extra days that MHO might not authorize.
  - ii. Related to above, MHO or other payer wants to minimize time in expensive and restrictive levels of care.
  - iii. Prescribers in acute settings only know child for short time and do not have to address the later side effects of medications, such as significant weight gain, therefore may tend to use these medications more often.

## **Issues Related To Informed Consent**

1. Required components of an appropriate informed consent process:
  - a. Caregiver / parent provides clinically relevant information about the child's current functioning and history.
  - b. Caregiver receives from prescriber information about the indications, risks, benefits, and alternatives of recommended treatment(s)
    - i. Use of this information depends on caregiver's capacity to understand, and the caregiver's interest in long-term implications of the choices.
    - ii. The accuracy of information provided about different alternatives depends on the prescriber's knowledge of:
      1. all the alternatives, including psychosocial treatments
      2. safety / risks of individual medications
      3. safety / risks of combined pharmacotherapy
      4. ability / willingness to articulate the risks (e.g. tardive dyskinesia related to antipsychotic medication)
      5. knowledge of appropriate safety monitoring
  - c. Caregiver / parent should make an informed decision guided primarily by the child's best interests, including considering the child's interests over the long run. For example, short-term

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# DRAFT

- decisions such as use of antipsychotics for acute behavioral control may not be in the best interest of the child’s long-term health.
- d. Informed consent in the typical parent-child situation (non-foster care) is guided by use of longitudinal knowledge of the individual child, including other relevant conditions and treatments and what has and hasn’t worked for the child over time.
  - e. Youth able to understand the information should have a more active role in the informed consent process.
2. Current system in which foster parent provides consent and informs caseworker is not well understood and documentation is uneven.
  3. Child advocates (JRP, OAC, CASA representative) have concerns about foster parents providing consent in that they are not legal guardian and have more incentives to medicate children.
  4. The split parenting role for children in foster care—physical care vs. legal custody—makes it technically impossible for either parent figure to perform all aspects of informed consent.
    - a. Caseworker has less information about the child’s day-to-day functioning and is not likely to directly communicate with the prescriber to hear all the relevant facts, thus consent could become “rubber stamp”.
    - b. Foster parent typically lacks historical information about the child including developmental history and medical and mental health care.
    - c. Foster parent does not have legal responsibility / accountability and is sometimes involved only temporarily with the child.
    - d. In some complex cases, there may need to be a third party whose role is *solely* to advocate for the child’s needs, including consideration of longterm consequences of any treatment choice.

## **Informed Consent Process**

Physicians and other prescribers diagnose and make recommendation about medically appropriate and effective treatment. The person affected or their substitute decision-maker consents or not to the recommended treatment. In an ideal situation, the physician/prescriber provides adequate information about the recommended treatment and any reasonable alternatives. After carefully weighing the information and factoring in their values, priorities,

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# DRAFT

experiences and unique situation, the person (or substitute) makes a decision. This decision is called “informed consent” in many arenas. In some situations, this process is more formal and well documented (e.g. surgery), but should occur with all medical/health decisions, including medications. As the decision becomes simpler and has less impact on the person, the process usually becomes less formal and less intensive.

Some children in foster care are in the “legal custody” of the Department of Human Services (Child Welfare). In OAR 413-020-0140, the Department delegates authority to make “routine medical care and dental care, including vaccinations and immunization; routine examinations and lab tests” to the person with “physical custody” (the foster provider). The Department’s SDA Manager retains authority for “emergency medical care and/or surgery, to include anesthesia” and “major medical and surgical procedures that are not extraordinary or controversial, to include anesthesia.”

There is no direction about whether psychotropic medications are routine or major medical decisions. However, in OAR 413-070-0470, the substitute caregiver is required to notify the Department caseworker within one working day of a new psychotropic medication prescription or a change in a current one. In OAR 413-070-0430, the caseworker is required to review the psychotropic medications with the supervisor and notify the CW RN if certain criteria are met: 1) child is less than six, 2) more than 3 psychotropic meds are prescribed, 3) more than 1 med in a class is prescribed, or 4) PRN psychotropic med is prescribed.

In addition, there is an administrative rule about behavior interventions (OAR 413-020-0200 to 413-020-0255). The caseworker is required to develop a behavior intervention plan for challenging behavior, but there is no mention of psychotropic medications.

## **OHP FFS Medicaid Medication Management Processes**

1. Prospective Drug Use Review (DUR): Medicaid mandated program sends messages to pharmacies, specific to a submitted drug claim, including notification of drug interactions, dose limits, age limits, etc. These are primarily informational messages but some are claim denials unless authorization criteria are met. Relevant initiatives include:

DRAFT

# DRAFT

- a. Require actual prescriber NPI for all psychotropics for children  $\leq 6$  years old. When the new MMIS is implemented June 30, a valid prescriber NPI will be required of ALL prescriptions
- b. maximum dose limits for stimulants
  - i. FDA labeling or
  - ii. An accumulative dose that EXCEEDS 2mg/kg/day of methylphenidate products or EXCEEDS 0.5mg/kg/day of amphetamine products or
  - iii. Pediatric/adolescent psychiatrists can currently prescribe any dose.
  - iv. Maximum duration for benzodiazepines sedatives
  - v. 15 doses/30 days or
  - vi. Covered OHP diagnosis (i.e. acceptable comorbidity)
  - vii. Maximum dose limits for combination opioids (FDA labeling for ASA/APAP component)
  - viii. Early refills denials if  $< 75\%$  of previous Rx used
2. Prior Authorization for covered diagnosis on prioritized list or appropriate therapy. This tool has not been used previously for psychotropic drugs because of stakeholder concerns about access. Relevant initiatives:
  - a. Lupron in children (new for April 2008)
  - b. Growth Hormone for short stature
3. Targeted Criteria-Based Fax Education
  - a. Transdermal Fentanyl use in opioid naïve
  - b. Acetaminophen overuse
  - c. Low-dose Seroquel (off-label)
4. Clinical Review of High Risk Indicators
  - a.  $>15$  drugs/180days
  - b.  $\geq 2$  atypical antipsychotics for  $\geq 90$  days
5. Prescription Change Requests
  - a. Anti-psychotic dose-consolidation (e.g. request to change 2 x 5mg to 1 x 10mg)
6. Academic Detailing
  - a. Promotion of generic antidepressants
  - b. Off-label Seroquel use
  - c. Antipsychotic drug selection
7. Pharmacy Lock-In Program

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## **Medicaid Billable Mental Health Contacts and Mental Health Assessments of Children Taken into DHS Custody: Summary of Findings**

- Of the 15,543 children who were taken into DHS custody at least once between 10/2003 and 12/2006, 3,468 (22.3%) received a medicaid billable service, within 60 days of the first time that DHS took custody that was associated with both a “mental health procedure” and a “mental health diagnosis.” 5,338 (34.3%) of the 15,543 children received such service within 120 days of the first time that DHS took custody.
- When the above sample of 15,543 was limited to the 8,790 children who were over the age of 3 as of the date that DHS first took custody, we find that 3,080 (35.0%) of the 8,790 received a medicaid billable service, within 60 days of the first time that DHS took custody, that was associated with both a mental health procedure and a mental health diagnosis. 4,653 (52.9%) of the 8,790 children received such service within 120 days of the first time that DHS took custody.
- For the 8,790 children who were over the age of 3 as of the date that DHS first took custody, we find that 1,872 (21.3%) received either a “mental health” assessment by a non-physician” (procedure code 90801) or a “psychiatric diagnostic interview examination” (procedure code H0031) within 60 days of the first date that DHS took custody 3,276 (37.3%) of the 8,790 children received one of these two procedures within 120 days of the first date that DHS took custody.
- The first mental health service following the time that DHS takes custody is not always a mental health assessment. For the 3,080 children aged 4-17 who received some kind of mental health service within 60 days of DHS custody, the first mental health services provided in the 60 day period were distributed as seen in Table 1. These services may or may not have included some form of mental health assessment.

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## **Psychotropic Prescription Drug Utilization Among Foster and non-Foster Children in Oregon Health Plan (OHP)**

### **Demographics, Enrollment, and Comorbidities**

- While children in foster care are representative of the general child population with respect to age and sex, those in foster care are more likely to be white.
- Foster children, on average, were more likely to be enrolled in OHP for a greater proportion of the study period compared to non-foster children (foster 77% versus non-Foster 65%). However, once enrolled, non-foster children were more likely to be enrolled in a capitated managed care plan versus fee-for-service (foster 56% versus non-foster 71%). Approximately 70% of non-foster children were enrolled in a capitated managed care plan for more than 75% of their OHP enrollment compared to 52% of foster children.
- Generally foster children had substantially greater prevalence of many psychiatric diagnoses such as developmental delay, depression, anxiety, PTSD, adjustment reactions, hyperkinetic disorders (e.g. ADHD), and bipolar disease.
- The distribution of Foster children was similar to the distribution of non-foster children. Slightly more foster children were found to reside in Lane and Clackamas County and slightly less in Multnomah and Marion County.

### **Psychotropic Utilization**

- Children in foster care are more than 3 fold more likely to have used a psychotropic (foster 27% versus non-foster 8%) during the study period. However, utilization varied by class from more than 5 fold higher stimulant use (foster 16% versus non-foster 3%)\*, more than 6 fold higher atypical antipsychotic and 2<sup>nd</sup> generation antidepressant use (foster 9% versus non-foster 1.3%, foster 13% versus non-foster 2% respectively).  
\*note higher use of stimulants among foster children may in part reflect non-carved out status of most stimulants and lower managed care enrollment.

DRAFT

# DRAFT

- Utilization of psychotropics was higher with respect to both prevalence of any use and intensity of use (foster 28 versus non-foster 14 day supply dispensed / month of eligibility)
- Foster children were also substantially more likely to be using more than one psychotropic concurrently
- The likelihood of being prescribed a psychotropic did not appear to be influenced by sex. The rate of use among foster children was approximately increased to the same degree compared to non-foster children regardless of sex. That is, male and female foster children were both roughly 3.6 times more likely to receive a psychotropic medication compared to non-foster children. This trend was reflected across classes.
- Overall, the likelihood of being prescribed a psychotropic did not appear to be influenced by age. Foster Children <6 years of age were no more likely to have a prescription for a psychotropic than foster Children  $\geq 6$  compared to their respective non-foster comparison groups. That is, both children <6 and  $\geq 6$  were 2-3 times more likely to receive a psychotropic if they were in foster care. Foster Children <6 did appear to be more likely to receive an antidepressant or atypical antipsychotic compared to foster children  $\geq 6$  relative to their non-foster children control groups. However, this finding is based on small numbers and may be an imprecise estimate.
- Age and sex did not appear to mediate the likelihood psychotropic polypharmacy.

## **Prescriber Characteristics**

- Children prescribed 2<sup>nd</sup> generation antidepressants and stimulants were more likely to receive them prescribed by a provider with a psychiatric specialty if in foster care. However, there appear to be no differences in the origins of atypical antipsychotic prescriptions between foster and non-foster care children.

DRAFT

# DRAFT

- There did not appear to be any appreciable differences between the origins of psychotropic polypharmacy between children in foster care compared to non-foster care.

## **Mental Health Assessments**

- Both foster and non-foster care children had relatively low rates of post psychotropic initiation mental health assessments (~24%-28%). The differences between assessment rates between foster and non-foster care children were variable and generally similar (or low in count) across drug classes

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# DRAFT

## Recommendations Regarding Psychotropic Medications for Foster Children

### Premises

1. It is not possible to determine whether the rates of psychotropic medication use in the child foster care population are appropriate. Since their psychiatric needs are higher than the general Medicaid population, it is expected that they will receive more of all mental health services (including psychopharmacology). Thus, the goal of new systems developed will be to get the right medications to the right children at the right time, in the context of psychosocial interventions that maximize their emotional and behavioral development.
2. However, there is general agreement that:
  - a. Psychotropic prescribing patterns are significantly affected by inadequate access to timely and adequate mental health services, and lack of integration between prescribers and the rest of the system of care (i.e. mental health/substance abuse, education, juvenile justice, developmental disabilities, primary health care).
  - b. How well and safely the emotional and behavioral needs of children in foster care are being met requires more monitoring and oversight.
3. A solution to these concerns must not be isolated to addressing psychopharmacology practices alone, but should be integrated with improving mental health and related services.
4. The balance of new resources should favor improving the adequacy of mental health services and not create new bureaucracy that poses barriers to timely services or does not enhance the adequacy of services.
5. Incentives should be provided for prescribers and consumers to be actively involved in the quality improvement process.
6. The statutory requirement for a mental health assessment within 60 days of being placed in foster care is not being met for a majority of children. This needs to be improved in conjunction with addressing prescribing practices.
7. The issues of informed consent are complex and will require careful consideration of the views of all stakeholders balanced with the goal of enhancing safety and quality of care.
8. The recommendations in this report complete the current phase of the DHS planning process that addresses the issues surrounding

DRAFT

# DRAFT

psychotropic medication use in foster children. Specific details of structuring a new oversight system should be derived in the next phase with input from stakeholders actively involved in service delivery or receiving services in order to maximize the likelihood of success. Several models should be identified and considered.

## **RECOMMENDATIONS**

### **Infrastructure**

DHS will increase resources for mental health and medication management staffing for the CAF (Children, Adults and Families) Foster Care Program. DHS will hire or contract with a physician to serve as Medical Director for CAF Child Welfare. The Medical Director will have specialty training in pediatric mental health and psychopharmacology. The Medical Director will lead development and evaluation of the medication management process for foster children, and have as a specific task to work on integrating of medication management with mental health and related services. The Medical Director will represent the agency in clinical matters to both the provider and client communities.

DHS will establish a CAF Child Welfare Advisory Committee to assist with strategic planning on psychotropic medication and integration with the system of care. The advisory committee will provide input to the next phase of strategic planning and then be an ongoing Advisory Committee. Efforts of the Medical Director and Child Welfare Advisory Committee will be aligned with other system of care development efforts, including the Wraparound Initiative and the Children's Systems Change Initiative, in order to reduce duplication and ensure that efforts are integrated. The Advisory Committee will include family members, youth, clinical experts (child and adolescent psychiatry, pediatrics / family medicine, nurse practitioners, mental health providers), pharmac, and others as appropriate.

The Advisory Committee will make use of existing resources within DHS, including the Oregon Health Resources Commission and its recently established Mental Health Sub-Committee, the Children's Systems Advisory Committee and the resources of the Oregon Drug Utilization Review Board. The panel can also make use of existing guidelines of the Child Welfare

DRAFT

# DRAFT

League of America, the American Academy of Pediatrics, the American Association of Child and Adolescent Psychiatry, as well as the guidelines developed by other states.

The Advisory Committee will also make use of resources of the current “DHS Medication Management Workgroup,” or similar multi-agency team, to coordinate expertise and programs. In addition to representatives from DHS Divisions, this team might include representatives from Oregon Youth Authority, Department of Education, the Juvenile Court system, etc.

The CAF Child Welfare Advisory Committee will assist with strategic planning over the next three months with the following goals:

1. Re-review the prescribing guidelines developed by the previous advisory panel that were implemented as review thresholds, and, incorporating information listed above, finalize the guidelines.
2. Review and select among the options for structuring and staffing a regional health/mental health tracking system to work in concert with the Medical Director.
3. Develop a plan for monitoring the adequacy and comprehensiveness of mental health and related services for children in foster care; and integrate medication treatments with other system of care interventions.
4. Develop recommendations regarding the provision of informed consent by DHS at certain levels of prescribing psychotropic medications. The Foster Care Program will need to develop a system to document informed consent and to ensure required notifications of legal parties to each case.
5. Develop accountability and feedback loops to ensure that policies and procedures are monitored and benchmarks achieved.

CAF will establish a Behavioral Health Review Team for the Foster Care Program to work closely with the Medical Director. This team will review cases that fall outside the prescribing guidelines established by the Advisory Committee. The team will include the Central Office RN Manager, CW Medical Director, other consulting physician and/or pharmacist as needed, and a mental health expert. Case reviews will address the entire treatment plan and will assist with getting the child access to other needed services.

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## **Staffing Options**

Child Welfare should develop a staff position that would function as a specialized case manager for foster children on psychotropic medications, serving as a local consultant to the caseworkers from a health care (nursing) or mental health background. Duties would include, for example, ensuring referral for mental health assessment, documentation of informed consent, review of medication logs, and educational services for other CW staff.

For foster children with severe behavioral disorders, CW should consider a “specialty caseload level” that is much lower than the usual caseload.

Child Welfare should consider developing/adopting a model of care that provides a higher level of support than is usually available in the current system for foster providers of children with intense needs. This could be an agency that would be responsible for the recruitment and training of foster providers, provide routine respite, have staff available to respond to crises and provide consultation and support on difficult behavioral health issues. The proctor care model in the DHS Seniors and People with Disabilities Division could be adapted to the needs of this population.

Any or all of these options could be initiated on a trial basis and reviewed through a quality improvement process.

## **Policies and Procedures**

Prescription of psychotropic medications at a specified level, as determined by the CAF Advisory Committee, will require review by the CAF Behavioral Health Review Team. For example, current DHS rules require review in the following circumstances:

- 1) A child under 6 years of age,
- 2) more than three psychotropic medications,
- 3) more than one psychotropic in a class (stimulants, anti-depressants, etc.),
- 4) psychotropic medication prescribed or administered “prn” (as needed)

DRAFT

# DRAFT

As a prerequisite at this specified level of prescribing, every foster child must have a comprehensive plan of care that should include all interventions and supports needed, including mental health/behavioral support, educational, recreational/mentoring, family support/ respite, etc. The Child Welfare caseworker is responsible for developing this comprehensive plan of care in collaboration with the foster parent(s), other providers and the youth if appropriate.

At this specified level of prescribing, every foster child must have a comprehensive mental health assessment within 60 days or already be in active mental health treatment. The mental health assessment and documentation of coordination between the medication prescriber and mental health provider must be available to the caseworker. All assessments should be provided to the prescriber and other clinicians involved with the child. Active coordination of care in which providers communicate as a group should take place and reimbursement for those meetings should be available to providers. A wraparound planning process will either be encouraged or required at this level of prescribing.

DHS will further explore, with the CAF Advisory Committee and other interested parties, the issues surrounding provision of informed consent, including whether the prescription of psychotropic medication is a major medical decision that requires DHS or its representatives to give consent before treatment. One option that will be considered is whether prescribing at the specified level outlined in the guidelines requires additional consent with the input of the Medical Director and/or Behavioral Health Team. Deliberations regarding informed consent issues, in particular, need to include all key stakeholders.

Medication prescribing at the specified level requires that the child be under the care of, or have consultation provided by, a child and adolescent psychiatrist. The documented consultation may be by telephone or video conference, and needs to include the medication management recommendations. Alternatively, DHS may require a second opinion regarding the medication regimen.

Medication management in the Foster Care Program will be included in the consumer/family advisory processes already established in DHS, so that input

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on development and implementation will be received from all involved parties in an ongoing fashion. This should include representatives of biological parents, foster parents, the juvenile court system, the education system, etc.

## **Data Systems**

FACIS (Family and Child Information System) will be developed to track psychotropic medication use of children in DHS custody on a real-time basis. Children who meet the established criteria would automatically be referred for review. The data system should allow psychotropic medications to be tracked by prescribing provider, placement of child, level of care of child, age of child, district, medication name (generic and brand) and medication class. In addition, procedures will be set up to correlate this data on a real-time basis with psychiatric diagnosis and mental health and related services the child is receiving at the time of the prescription.

Quarterly (or monthly) data runs for all foster children covered on the Oregon Health Plan will be performed by the DMAP DUR Clinical Review Program to monitor the established high-risk indicators. Information on psychotropic medication use will be made available to the CW Medical Director, CW Behavioral Health Review Team, as well as to the CW District nurses, DMAP Medical Director and DHS Addictions and Mental Health Division representatives.

Data systems capacity to identify actual prescribers will be developed utilizing required NPI (National Provider Identifier) numbers and the new Medicaid Management Information System.

Oregon DHS will participate in a multi-state project involving data analysis of atypical anti-psychotic medication use in children (including the subset of children in foster care), sponsored by the Agency for Healthcare Quality and Research (Medicaid Medical Directors Network).

## **Training and Education**

Training and education will be a central aspect of new infrastructure and processes. Expenditure of resources is necessary to develop skills in the workforce that are not available at present, including skills of foster parents, medical care providers and mental health providers. Models of quality

DRAFT

# DRAFT

improvement already being used successfully by the provider community will be encouraged, and providers and consumers (including youth) will be involved in developing and providing training and education.

With the CW Advisory Committee's input, DHS will sponsor pilot projects to examine different mechanisms for improving quality of care, including but not limited to projects aimed at improving prescribing practices from within the prescriber community. Projects could include selected prescribing categories (for example, use of sleep medications instead of evidence-based sleep hygiene strategies; atypical antipsychotic use without adequate monitoring or informed consent, etc.). Pilot projects could also examine linkage of services in partnership with primary care providers, child psychiatrists and the mental health system.

Child Welfare will develop training capacity to implement mandatory training for DHS caseworkers and foster parents regarding psychotropic medication management (which includes updated required refresher classes). The training will include how medications should be integrated into an overall treatment plan with interventions from multiple agencies and how to access and coordinate these services. Training will be offered in the wraparound planning process for children and youth with more serious mental health needs.

DMAP will adapt the current retrospective Drug Utilization Review educational program to include the prescribing guidelines developed by the CAF Advisory Committee. DMAP will develop interventions to address frequently encountered practices, and those interventions will be integrated and prioritized based on program goals.

DMAP Pharmacy Program will refine and expand the successful pilot academic detailing and profiling service to disseminate information about safety and outlier prescribing practices. Academic detailing to prescribers in Oregon will now be supported by grant funding administered by the State Office for Oregon Health Planning and Research. Specific feedback reports can be generated by the DMAP DUR Clinical Review Program, comparing prescribing patterns relative to peers and including specific recommendations for change.

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