

MARYLAND HEALTH CARE OVERSIGHT AND COORDINATION PLAN



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Maryland Health Care Oversight and Coordination Plan

INTRODUCTION

Maryland developed a Health Care Oversight and Coordination Plan as part of the Administration on Children, Youth and Families ACYF-CB-PI-15-03 guidelines issued March 31, 2015, the new *“plan should reflect lessons learned since the development of the prior plan and continue to strengthen activities to improve the health care and oversight of children and youth in foster care over the next five years.”*

Additionally, *“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.”*

The Health Care Oversight and Coordination Plan must include an outline of all of the items listed below, enumerated in statute at section 422(b)(15)(A)(i)- (vii) of the Act:

- *A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;*
- *How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child’s maltreatment and removal from home;*
- *How medical information will be updated and appropriately shared, which may include*
- *developing and implementing an electronic health record;*
- *Steps to ensure continuity of health care services, which may include establishing a*
- *medical home for every child in care;*
- *The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;*
- *How the state actively consults with and involves 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; and*
- *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, healthcare proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.*

DEFINITIONS

Early and Periodic Screening, Diagnosis Treatment (EPSDT) means the provision, to individuals younger than 21 years old, of preventive health care pursuant to 42 CFR§441.50 et.seq. (1981), and other health care services, diagnostic services and treatment services that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions by EPSDT screening services.

EPSDT-certified provider means a physician or nurse practitioner who is certified by the Department of Health and Mental Hygiene's (DHMH) EPSDT program to provide comprehensive well-child services according to DHMH periodicity schedule and program standards to enrollees younger than 21 years old.

EPSDT comprehensive well-child services means (a) all the screening services provided by an EPSDT certified provider that are required or recommended on the EPSDT periodicity schedule; and (b) health care services to diagnose, treat, or refer problems or conditions discovered during the comprehensive well-child service.

EPSDT partial or inter-periodic well-child service means (a) a well-child service provided at times different than those outlined in the EPSDT periodicity schedule; or (b) any encounter by a healthcare practitioner necessary to diagnose or identify a condition and recommend a course of treatment.

EPSDT periodicity schedule means the Department of Health and Mental Hygiene's approved list of required or recommended preventive health care services which are to be performed at specified ages.

Patient Centered Medical Home means a primary care practice organized to provide a first, coordinated, ongoing, and comprehensive source of care to patients to: (1) Foster a partnership with a child in Out-of-Home Placement; (2) Coordinate health care services for a child in Out-of-Home Placement; and (3) Exchange medical information with carriers, other providers, and children in Out-of-Home Placement.

Managed Care Organization (MCO) means (a) a certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments; or (b) a corporation that: (i) Is a managed care system that is authorized to receive medical assistance prepaid capitation payments; (ii) enrolls only program recipients or individuals or families served under the Maryland Children's Health Program; and (iii) is subject to the requirements of §15-102.4 of the Health-General Article.

Primary Care Physician (PCP) means a practitioner who is the primary coordinator of care for the enrollee, and whose responsibility it is to provide accessible, continuous, comprehensive, and coordinated health care services covering the full range of benefits

required by the Maryland Medicaid Managed Care Program as specified in COMAR 10.09.67.

DSM-5: The Diagnostic and Statistical Manual of Mental Disorders, (5th Edition) that is used by clinicians and psychiatrists to diagnose psychiatric illnesses. The DSM-5 is published by the American Psychiatric Association and covers all categories of mental health disorders for both adults and children

Psychotropic Medication: medication that affects or alters thought processes, mood, sleep or behavior. A medication classification depends upon its stated or intended effect. Psychotropic medications include, but are not limited to:

Antipsychotics- for treatment of psychosis and other mental and emotional conditions.

Antidepressants- for treatment of depression.

Anxiolytics - for treatment of anxiety.

Mood stabilizing, anticonvulsants and lithium - for treatment of bipolar disorder (manic-depressive), aggressive behavior, impulse control disorders, and severe symptoms associated with mood disorders and schizoaffective disorders and schizophrenia.

Stimulants and non-stimulants: for treatment of attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD).

Prescriber- means any clinician who is authorized to prescribe psychotropic medications, i.e. child and adolescent psychiatrists, general psychiatrists, pediatricians, primary care physicians (PCP) or psychiatric nurse practitioners.

Health Care Services 2015-2019

The Department of Human Resources (DHR) is committed to ensuring that children in foster care have access to appropriate and comprehensive health care benefits that encompass medical care, behavioral health services, dental services, and vision health. This work is done in collaboration with the Department of Health and Mental Hygiene. The Maryland state regulation in reference to coordination of health care services for children in foster care is as follows:

Maryland Department of Health and Mental Hygiene Children in State-Supervised Care

In accordance with COMAR 10.09.65.13, Maryland Medicaid Managed Care Organizations (MCOs) shall:

- Provide or arrange to provide all Medicaid-covered services required to comply with State statutes and regulations mandating health and mental health services for children in State-supervised care;
- Ensure that continuity and coordination of care, provided locally to the extent the services are available, to an enrollee who is a child in State-supervised care;
- Expedite a change of providers within its panel upon the move of an enrollee who is a child in State-supervised care to a new geographic area served by the MCO;
- On request of the responsible State or local agency, dis-enroll a child in State-supervised care from the current MCO and enroll in an MCO serving the group facility in which the child resides, members of the foster care family, or other children in foster care placement with the child;
- Permit the self-referral of a child in State-supervised care to an initial examination, including a mental health screen and pay for all portions of the examination, except for the mental health screen, which shall be paid for by the Specialty Mental Health System; and
- Appoint a liaison to coordinate services to a child in State-supervised care with the responsible State or local agencies.

THE MARYLAND HEALTHY KIDS/EPSTD PROGRAM

The Maryland Healthy Kids program promotes access to and ensures availability of quality health care for Medical Assistance children, teens and young adults less than 21 years of age. This program provides appropriate practice-based performance improvement assessments and targeted interventions to enhance the quality of health services delivered by Medicaid providers to eligible recipients less than 21 years of age. All of Maryland's foster children receive Maryland Medicaid services and follow the schedule (Attachment 1) for Early Periodic Screening Diagnostic Treatment (EPSTD). EPSTD also includes addressing the emotional trauma children experience as a result of being removed from their home. At each visit, the medical practitioner assesses the child's mental health and behavioral needs and refers as appropriate.

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 a risk is identified, and
Treatment	Control, correct or reduce health problems found.

*Table from Medicaid.gov

TYPE OF VISIT:

Initial Health Screen/Placement Exam: An initial Health Screen/Placement Exam is to be completed within 5 business days of entering foster care. This exam should be considered an exam to determine the need for acute care management. Components of the exam should include growth parameters, physical exam of all body surfaces to identify signs of abuse and/or neglect, identifying and treating infectious/communicable diseases, acute dental issues, acute mental health issues, and evaluating status of known chronic medical conditions. Recommendation for follow-up should include acute medical needs.

Comprehensive Medical Exam/EPSTD/Well Child Exam: A comprehensive medical exam is to be completed within 60 days of entering foster care regardless of when the child's last well child exam was completed. This exam should be considered a well-child exam or complete physical that meets EPSTD standards. Well child exams should be completed according to the preventive health care periodicity schedule. Recommendations for follow-up should include acute medical needs as well as routine follow-up recommendations.

Follow-Up/Sick/Emergency Exam: Recommendations should include acute medical needs and follow up with primary care provider.

Dental Exam: Dental exams should be completed according to the EPSTD standards. Recommendations should include acute dental needs as well as routine dental follow-up.

CURRENT DHR HEALTHCARE POLICY

On April 15, 2014, DHR issued a policy, SSA-CW #14-17 Oversight and Monitoring of Healthcare Services, outlining the responsibilities of the local Department of Social Services regarding health care oversight and monitoring of children who enter Out-of-Home Placement. The following is a list of activities that are mandated for every child in the custody of the department:

1. The case worker obtains the signature of a parent or legal guardian on the Consent to Health Care and Release of Records (DHR 631-F.see appendix)
2. The caseworker enrolls the child in the Maryland Medical Assistance Plan (MD-MA) as soon as possible after the initial placement. Enrollment in MD-MA establishes the medical home for the child and a primary care physician is selected at that time. For continuity of medical care, if the child has a primary care physician upon entering care, the caseworker makes every effort for the child to continue to use this provider. In the event that a child cannot continue care with their primary care physician, the caseworker will contact the managed care organization (MCO) and obtain all medical history on the child and document that information in MD CHESSIE, as well as on the child's health passport. This ensures a continuity of care and transfer of information between providers.
3. The caseworker ensures that the child has an initial health care screening, provided by a primary care physician (PCP) who is certified by the Maryland Healthy Kids Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program preferably prior to or within 24 hours of removal, but no later than 5 days from removal.
4. The caseworker ensures that the child has a complete comprehensive health assessment within 60 calendar days of entering Out-of-Home Placement.
5. The caseworker ensures that children in the care of a local department shall have an annual well-child examination and that appropriate follow-up appointments are made, referrals are made and followed up on, and that evaluation, diagnosis, and treatment are secured to meet the child's health care needs. The supervisor ensures that all documentation is in MD CHESSIE.
6. All children in the Out-of-Home Placement must follow the EPSDT schedule of preventive health care.
7. The caseworker shall schedule a dental care visit for children one (1) year and older, which shall include check-ups every six months and necessary dental treatment to be provided by the MCO or fee-for-service dental provider.
8. The caseworker schedules a vision exam once a year in addition to any vision screening performed as part of the EPSDT exam.
9. The caseworker maintains the child's Health Passport which contains historical and current medical information needed by the caretaker and physician or clinic to ensure that the child's health needs have been identified and are being addressed.

10. The caseworker documents all of the health information and documentation into MD CHESSIE. Any paper documents are scanned into the MD CHESSIE system.

CONSENT FOR MEDICAL TREATMENT AND HEALTH CARE SERVICES

Upon entry into Out-of-Home Placement the Local Department of Social Services (LDSS) shall obtain the signature of a parent or legal guardian on the Consent to Health Care and Release of Records, (DHR 631-F). If it is not possible to obtain such consent, the LDSS shall petition the court for limited medical guardianship. No consent is required, if the parents' rights have been terminated. Unless otherwise specified, youth that are in Out-of-Home Placements that are age 18 and older are considered competent to consent for medical treatment and health care services when required.

Minors (*persons under the age of 18*) May Consent for Health Care Services.

In Maryland there are certain health care services that minors, (*persons under the age of 18*) have the same capacity as an adult to consent to treatment. When a minor is consenting for health care services the LDSS shall support the minor with the following:

- Providing and reviewing information about the consented health care services with the minor.
- Ensuring that the minor has transportation to all appointments, including follow-up appointments.
- Ensuring that an adult accompanies the minor on appointments.
- If prescriptions are given, ensuring that all prescriptions are filled and that the minor understands the importance of adhering to regimen.
- If the minor's recovery requires them to be absent from school, ensure that the minor's school is notified so that the absence will be considered an excused absence.

Health Care Services that a Minor (i.e. person under age 18) Can Give Consent

Health Care Service	Law	Confidentiality and /or Informing Obligation of the Health Care Provider
General Medical or Dental Treatment	<p>A minor (<i>i.e. person under the age of 18</i>) has the same capacity as an adult to consent to medical or dental treatment if the minor:</p> <ol style="list-style-type: none"> 1) Is married; 2) Is parent of a child; 3) i. Is living separate & apart from minor's parents, or guardian, whether with or without consent of minor's parent, parents, or guardian; and ii. Is self-supporting, regardless of source of minor's income. <p>[Md. Code Ann., Health-Gen II</p>	<p>Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor, except information about an abortion</p> <p>[Md. Code Ann., Health-Gen II § 20-102(f)]</p>

Health Care Service	Law	Confidentiality and /or Informing Obligation of the Health Care Provider
	§20-102(a)]	
Pregnancy	A minor (<i>i.e. a person under the age of 18</i>) has the capacity as an adult to consent to treatment for or advice about pregnancy other than sterilization. [Md. Code Ann., Health-Gen. II § 20-102(c)(1)-(5)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor, except information about an abortion [Md. Code Ann., Health-Gen II § 20-102(f)]
Contraception	A minor (<i>i.e. a person under the age of 18</i>) has the capacity as an adult to consent to treatment for or advice about contraception other than sterilization. [Md. Code Ann., Health-Gen. II §20-102(c) (1)-(5)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor, except information about an abortion [Md. Code Ann., Health-Gen II § 20-102(f)]
Diagnosis and/or Treatment For Sexually Transmitted Disease	A minor (<i>i.e. a person under the age of 18</i>) has the same capacity as an adult to consent to treatment for or advice about venereal disease [Md. Code Ann., Health-Gen. II § 20-102 (c) (1)-(5)]	Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor, except information about an abortion [Md. Code Ann., Health-Gen II § 20-102(f)]
AIDS/HIV Testing and Treatment	A minor (<i>i.e., a person under the age of 18</i>) has the same	Without the consent of or over the express objection of a minor,

Health Care Service	Law	Confidentiality and /or Informing Obligation of the Health Care Provider
	<p>capacity as an adult to consent to treatment for or advice about venereal disease [Md. Code Ann., Health-Gen. II § 20-102 (c) (1)-(5)]</p>	<p>the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor, except information an abortion [Md. Code Ann., Health-Gen II § 20-102(f)]</p>
<p>Abortion</p>	<p>A physician may not perform an abortion on an unmarried minor unless the physician first gives notice to a parent or guardian of the minor, except as provided with respect to “incomplete notice” and “waiver of notice”. Md. Code Ann., Health-Gen. II § 20-103(a)]</p>	<p><i>Waiver of Notice</i>- No notice required, if, in the professional judgment of the physician:</p> <ol style="list-style-type: none"> 1. Notice to the parent or guardian may lead to physical or emotional abuse of the minor; 2. The minor is mature and capable of giving informed consent to an abortion ; or 3. Notification would not be in the best interest of the minor. <p><i>Incomplete Notice</i>-No notice required if:</p> <ol style="list-style-type: none"> 1. The minor does not live with a parent or guardian; and 2. A reasonable effort to give notice to a parent or guardian is unsuccessful. <p>[Md. Code Ann., Health-Gen. II § 20-103(b)]</p> <p>A physician is not liable for civil damages or subject to criminal penalty for a decision under this subsection not to give notice. [Md. Code Ann., Health-Gen. II § 20-103 (c)]</p> <p><i>Notice Prohibited</i>- A physician may not provide notice to a parent or guardian if the minor decides not to have the abortion [Md. Code Ann., Health-Gen. II § 20-103 (e)]</p>

Health Care Service	Law	Confidentiality and /or Informing Obligation of the Health Care Provider
Emergency Medical Services	<p>A minor (<i>i.e. a person under the age of 18</i>) has the same capacity as an adult to consent to medical treatment if, in the judgment of the attending physician, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual.</p> <p>[Md. Code Ann., Health-Gen. II § 20-102(b)]</p>	<p>The health care provider shall inform the minor's parent or guardian.</p> <p>The health care provider may treat a patient who is incapable of making an informed decision, without consent, if the treatment is of an emergency nature; the person who is authorized to give consent is not available immediately; and the attending physician determines that there is substantial risk of death or immediate and serious harm to the patient and that the life or health of the patient would be affected adversely by delaying treatment to obtain consent.</p> <p>[Md. Code Ann., Health-Gen. II § 5-607]</p>
Drug and Alcohol Abuse Treatment	<p>A minor (<i>i.e., a person under the age of 18</i>) has the same capacity as an adult to consent to treatment for advice about drug abuse and alcoholism [Md. Code Ann., Health-Gen. II § 20-102 (c) (1)&(5)]</p> <p><i>Psychological treatment for drug abuse or alcoholism</i></p> <p>A minor has the capacity to consent to psychological treatment for drug abuse or alcoholism if, in the judgment of the attending physician or a psychologist, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual [Md. Code Ann., Health-Gen. II § 20-102 (d)]</p> <p><i>Refusal of treatment</i></p>	<p>Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]</p>

Health Care Service	Law	Confidentiality and /or Informing Obligation of the Health Care Provider
	<p>The capacity of a minor to consent to treatment for drug abuse or alcoholism does not include the capacity to refuse treatment in a certified inpatient alcohol or drug treatment program for which a parent /guardian has given consent [Md. Code Ann., Health-Gen. II § 20-102(c-1)]</p>	
Outpatient Mental Health Services	<p>A minor who is 16 years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, or a clinic [Md. Code Ann., Health-Gen. II § 20-104(a)] The capacity of a minor to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic does not include the capacity to refuse consultation, diagnosis, or treatment for a mental or emotional disorder for which a parent, guardian, or custodian of the minor has given consent</p>	<p>Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]</p>
Sexual Assault and Rape Services	<p>A minor (<i>i.e., a person under the age of 18</i>) has the same capacity as an adult to consent to:</p> <ul style="list-style-type: none"> · Physical examination and treatment of injuries · Physical examination to obtain evidence from an alleged rape or sexual offense. [Md. Code Ann., Health-Gen. II 	<p>Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]</p>

Health Care Service	Law	Confidentiality and /or Informing Obligation of the Health Care Provider
	§ 20-102 (c)(6)-(7)]	
Admission to Detention Center	<p>A minor (i.e. a person under the age of 18) has the same capacity as an adult to consent to:</p> <ul style="list-style-type: none"> · Initial medical screening and physical examination on and after admission into a detention center <p>[Md. Code Ann., Health-Gen. II § 20-102 (c)(8)]</p>	<p>Without the consent of or over the express objection of a minor, the health care provider may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor [Md. Code Ann., Health-Gen. II § 20-102(f)]</p>

OBTAINING MEDICAL RECORDS AND HEALTH CARE INFORMATION

In order to ensure continuity of care and a coordinated health plan, caseworkers obtain medical history of a child in Out-of-Home as often as possible. The following Maryland statute allows the caseworker to obtain all of the records needed:

In accordance with Maryland law (Md. Code Ann., Health-Gen. I §4-303 (a) (b)(1)-(5)) a health care provider shall disclose a medical record on the authorization of a person in interest. An authorization shall:

- Be in writing, dated, and signed by the person of interest;
- State the name of the health care provider;
- Identify to whom the information is to be disclosed;
- State the period of time that the authorization is valid; which may not exceed 1 year, except:
 - In cases of criminal justice referrals, in which case the authorization shall be valid until 30 days following final disposition; or
 - In cases where the patient on who the medical record is kept is a resident of a nursing home, in which case the authorization shall be valid until revoked, or for anytime period specified in the authorization; and
- Apply only to a medical record developed by the health care provider unless in writing:
 - The authorization specifies disclosure of a medical record that the health care provider has received from another provider; and
 - The other provider has not prohibited re-disclosure.

As provided in § 4-303 (e)(2)-(3) of the Md. Code Ann., Health Gen article, except in cases of criminal justice referrals, a person of interest may revoke an authorization in

writing. A revocation of an authorization becomes effective on the date of receipt by the health care provider. A disclosure made before the effective date of a revocation is not affected by the revocation.

In accordance with Maryland law (Md. Code Ann., Health-Gen. I § 4-301(k)(4)-(5)), the following qualify as a “ Person in interest” who may access the medical records of minors:

- A minor, if the medical record concerns treatment to which the minor has the right to consent and has consented.
- A parent, guardian, custodian, or a representatives of the minor designated by a court, in the discretion of the attending who provided the treatment to the minor, as provided in §20-102 or § 20-104 of the Md. Code Ann., Health-Gen Article.
- A parent of the minor, except if the parent’s authority to consent to health care for the minor has been specifically limited by a court order or valid separation agreement entered into by the parents of the minor.
- A person authorized to consent to health care for the minor consistent with the authority granted.
- An attorney appointed in writing by an authorized person as listed above.

DOCUMENTATION AND SHARING OF HEALTH CARE INFORMATION (HEALTH PASSPORT and MD CHESSIE)

Health Passport (DHR/SSA 631 series, See Attachment 1 and Attachment 2)

All components of a child's health care are documented in Maryland’s Health Passport. Every child in Out-of-Home Placement receives a health passport. The caseworker and /or caregiver accompany the child on subsequent medical visits during which the physician consults with the caseworker and / or caregiver regarding the child’s health and completes the health passport. Maryland physicians must complete the health passport forms each time they examine the child.

The passport is given to the caregiver at the time of placement and is required to be taken to every appointment. The original of the forms remains in the Health Passport. Copies of the forms are placed in the child’s case record. The Health Passport is returned to the Local Department of Social Services at the time the child leaves the placement. The passport is given to the adoptive parents at placement, to birth parents when the child returns home, or to the young adult when they reach the age18, as appropriate, and at no cost.

The Health Passport performs the following functions:

- The passport contains historical and current medical information needed by the caretaker and physicians or clinic to ensure that the child’s health needs have been identified and are being addressed.
- The health forms serve as the caseworker’s documentation for compliance purposes.

- The health passport also serves as a record that provides health care documentation for children who are adopted or who are permanently separated from their families.

MD CHESSIE HEALTH CARE SCREENS (MEDIALERT, HEALTH HISTORY, AND DEVELOPMENT FUNCTIONING)

The child's health needs and treatment are also documented in MD CHESSIE in the health screens. This provides caseworkers and supervisors the ability to monitor and track the health care needs of the child. It is the responsibility of the supervisor to ensure that the worker has documented the record appropriately.

Pursuant to Title VI- of the Social Security Act child welfare agencies are required to maintain health care records on children and youth in Out-of-Home Placement. Youth between the ages of 18-20 that are still in Out-of-Home Placement and consenting for their health care treatment, provide documentation of health care services to the Local Department of Social Services for the purpose of maintaining their health record in MD CHESSIE. MD CHESSIE is the official case plan file for each youth in Out-of-Home Placement. MD CHESSIE has a Health folder which maintains the health record for children and youth in Out-of-Home Placement. Within the health folder, there are three additional health folders; which include the MediAlert Folder, Health History Folder, and Development Functioning Folder. To ensure proper oversight and monitoring of health care services, the LDSS caseworker ensures that each of the folders in the health folder is fully completed with current and accurate health care information on each youth in Out-of-Home Placement. The caseworker also communicates regularly with the primary care physician and at least monthly with the foster parent to ensure that the child is receiving all follow up and recommended care.

MediAlert Folder

The following health care information is monitored and maintained in the MediAlert Tab:

- Examination Information,
- Chronic Health Information,
- Allergies/Special Needs/Hygiene/Phobias Information,
- Medications, and
- Health Insurance.

Below is an example of a completed MD CHESSIE MediAlert Examination, Medication, and Insurance Tabs.

Examination Information

Service Cases > Dresser, Budget, (#20000921) > Clients > Dresser, Kristin (#20003603) > Health > Med-Alert

Examination | Chronic | Allergies/Sp. Needs/Hygiene/Phobias | Medication | Insurance

Info Provided Name	Relationship	Nature of Exam	Date of Examination
Dr Phil Mcgraw	Medical Professional	Annual Health Exam	01/06/2014

Examination Information

*Info Provided By

Client List: Household Collateral

Collateral List: Dr Phil Mcgraw

*Info Provided Name: Dr Phil Mcgraw

Relationship: Medical Professional

Appointment Information

Appt. Date: 01/06/2014 Appt Kept Next Appt. Date: 01/29/2015

*Nature of Exam: Annual Health Examination Lab Test:

Specialty Exam: GYN Consent for HIV Test Received:

Physician Information

Physician Name: Dr. Phil Mcgraw

Specialty: OBGYN

Affiliation/Organization: OBYN of Towson

Address: 1220 York Road Baltimore, MD 21212 [Edit](#)

Contact Info: [Edit](#)

Work: (410) 526-6400 Ext:

Fax: - -

Physician's Recommendations: [Edit](#)

Return follow up scheduled

Comments: [Edit](#)

Reviewed birth control methods with Kristin

The worker should document any follow up needed for the child on this MD CHESIE screen. The supervisor ensures that the documentation and follow up are completed.

Medication Information:

Service Cases > Dresser, Bridget (#2000921) > Clients > Dresser, Kristin (#2000920) > Health > MediAlert

Examination Chronic Allergies/Sp. Needs/Hygiene/Phobias **Medication** Insurance

Info Provided Name	Relationship	Medication Name	Date Started
Bridget Dresser (1970-07-28)	(200) Daughter (Biological)	Lasix	01/09/2012

[Current Medications](#)

Medication Information

*Info Provided By

Client List: Collateral List:

Household Collateral

*Info Provided Name:

Relationship:

Medication Details

*Medication Name:

Dose/Frequency:

Date Started: Date to Stop: Date Stopped:

Reason/Purpose: [Edit](#)

Prescribed for because Kristin was diagnosed with high blood pressure. Medication help to maintain a normal blood pressure.

Physician Information

Physician Name:

Affiliation/Organization:

Address: [Edit](#)

Contact Info: [Edit](#)

Work: Ext:

Fax:

Pharmacy Information

Pharmacy Name:

Pharmacy Phone:

Comments: [Edit](#)

Medication is being monitored by Dr. Block and should be taken as prescribed.

All medications that the child is prescribed should be documented in this folder. This would include all psychotropic medications as well. The caseworker ensures that this is up to date and the supervisor reviews the MD CHESSE record as well. The caseworker also ensures that the information in the child's Health Passport is up to date. This ensures the continuity of care.

Insurance information:

Service Cases > Dresser, Bridget (#20000821) > Clients > Dresser, Kristin (#20003603) > Health > Med-Alert

Examination | Chronic | Allergies/Sp. Needs/Hygiene/Phobias | Medication | **Insurance**

Info Provided Name	Relationship	Policy Holder Name	Insurance Type
Bridget Dresser (1970-07-28)	Daughter (Biological)		Medicaid (Medical Ass

Insurance Information

*Info Provided By:
 Household Collateral CARES
 Client List: [] Collateral List: []

*Info Provided Name: **Bridget Dresser (1970-07-28) (20003600)**
 Relationship: Daughter (Biological)

Insurance Background

*Insurance Type: **Medicaid (Medical Assistance)** *Other Medical Coverage: [] MA or Health Insurance #: 387904
 Medicaid Program Start Date: 00/00/0000 End Date: 00/00/0000
 Has Insurance Been Discussed? MA Type: []

Policy Information

HMO/MCO/MCHP: Medicaid (Medical Assistance)
 Policy Number: 898767 Group Number: 012345 Start Date: 07/14/2009
 Primary Care/Assigned Provider: Bridget Dresser End Date: 01/25/2013

Address: [] [Edit](#) Contact Info: [] [Edit](#)
 Work: () - [] Ext: []
 Fax: () - []

Policy Holder Information

Name: [] Name (not listed): []
 SSN: 000-00-0000 Relation to the Client: []
 Address: [] [Edit](#) Contact Info: [] [Edit](#)
 Home: () - []
 Work: () - [] Ext: []

Comments: [] [Edit](#)

Health History Folder

The following health care information is monitored and maintained in the Health History Folder:

- Under 5 Health Care Information,
- Birth Information,
- Sexual Information,
- Hospitalization Information,
- Immunization Information, and
- Family Medical History Information

Below is an example of a completed MD CHESIE Health History Hospitalization and Immunization Information Tabs.

Hospitalization:

The screenshot shows a web application interface for a patient's health history. The breadcrumb trail at the top reads: "Service Cases > Dresser, Bridget, [#20000921] > Clients > Dresser, Kristin [#20003603] > Health > Health History". The interface has a navigation bar with tabs: "Under 5 Years", "Birth Info", "Sexual Info", "Hospitalization" (selected), "Immunization", and "Family History".

Info Provided	Name	Relationship	Type of Hospitalization	Reason for Hospitalization
Bridget Dresser	[1970-0]	Daughter (Biologic)	Medical (Specify)	Eye Injury

Hospitalizations Information

*Info Provided By: Household Collateral
Client List: [Dropdown] Collateral List: [Dropdown]

*Info Provided Name: **Bridget Dresser [1970-07-28] (20003600)**

Relationship: **Daughter (Biological)**

*Type of Hospitalization: **Medical (Specify)** *Reason for Hospitalization: **Eye Injury**

Start Date: **05/09/2012** End Date: **05/10/2012**

Reason/Diagnosis: [Edit](#)
Kristin injured her right eye while participating in Physical Education in school. She was taken to the hospital and recieved ten stiches and was keep overnight for observation.

Hospital Information

Name of Hospital: **Northwest Hospital**

Address: **2121 Old Court Road Baltimore, MD 21208** [Edit](#)

Contact Info: [Edit](#)
Work: **[410]-230-7531** Ext: []
Fax: **[410]-230-6509**

Comments: [Edit](#)
Kristin had a full recovery. There was no other damage to her right eye.

Immunization Information:

Service Cases > Dresser, Bridget (#2000921) > Clients > Dresser, Kristin (#20003503) > Health > Health History

New Save Delete Close

Under 5 Years Birth Info Sexual Info Hospitalization **Immunization** Family History

Info Provided by Name	Relationship	Immunization Type	Date	Next Due Date
Mrs. Betty White	Teacher	DPT - Dose 5	05/10/2000	

Immunization Information

*Info Provided By

Client List: Collateral List:

Household Collateral

*Info Provided Name: Mrs. Betty White

Relationship: Teacher

Immunization Information Detail

*Type: DPT - Dose 5 *Not Immunized

Date: 05/10/2000 Next Due Date: 00/00/0000

Reason for Non-Immunization: [Edit](#)

Physician/Clinic Information

Physician/Clinic: Upstate Community Clinic

Address: [Edit](#) 2020 Main Circle Windsor Mill, MD 21244

Contact Info: [Edit](#)

Work: (410) 221-3456 Ext:

Fax: (410) 221-6789

Certified Copy in Hard File

Comments: [Edit](#)

Development Status Folder

The following health care information is monitored and maintained in the Development Status Folder:

- Mobility/Speech,
- Feeding,
- Sleeping, and
- Elimination.

Below is an example of a completed MD CHESIE Development Status Mobility Tab.

Development Status Mobility:

The screenshot shows a web-based interface for the MD CHESIE Development Status Mobility Tab. The breadcrumb trail at the top reads: Service Cases > Dresser, Bridget (#20000921) > Clients > Dresser, Kristin (#20003603) > Health > Development Status. The interface has a navigation bar with tabs for Mobility/Speech, Feeding, Sleeping, and Elimination. The Mobility/Speech tab is active. Below the navigation bar is a table with two columns: Info Provided Name and Relationship. The table contains one entry: Bridget Dresser (1970-07-28) (20003600) with the relationship Daughter (Biological). Below the table is a section titled Mobility/Speech Information. It includes a dropdown for *Info Provided By with options Household (selected) and Collateral. Below this are dropdowns for Client List and Collateral List. The *Info Provided Name field contains Bridget Dresser (1970-07-28) (20003600) and the Relationship field contains Daughter (Biological). There is a checkbox for Mobility/Speech Info Unknown. The Speech section has a dropdown set to Sentences. The Age When Child First section has input fields for Sat Up (9 months), Walked (10 months), and Talked (12 months). The Mobility section has a list of activities: Runs, Sits, Stands, and Walks. There is a Select button next to the Mobility list. At the bottom, there is a Comments field with the text: (If you checked unknown, describe efforts made to collect information): and an Edit button.

MAKING ALL THE CHILDREN HEALTHY (MATCH) PROGRAM

Making All Children Healthy (MATCH) program is a Baltimore City initiative that was developed and implemented by the Baltimore City Department of Social Services (BCDSS) in collaboration with Healthcare Access Maryland. MATCH oversees the health care of children in Baltimore City's foster care, which accounts for 50% of youth in foster care statewide. MATCH provides medical case management and health care coordination for children and youth in foster care. In addition to coordinating medical and dental care, the program assures the completion of a mental health assessment of youth upon entry to foster care, completes referrals, and follows mental health treatment. The program incorporates a child psychiatrist consultant in their review of cases with complex psychiatric health needs. Baltimore City DSS in collaboration with the MATCH program are implementing an electronic medical records system. DHR will solicit feedback from Baltimore City DSS, six months after the implementation in order to evaluate this system and practice. DHR will be examining if this is a system that could work statewide.

HEALTH INFORMATION FOR TRANSITIONING YOUTH EXITING CARE

The Local Department of Social Services (LDSS) shall provide the child who has exited Out-of-Home Placement (OHP) a copy of his or her personal health records, at no cost to the child, when the child exits by attainment of age or the child exits prior to age 21, and requests the personal health records.

- A former OHP child, age 21 or older, may request the health information from the department.
- Personal information on the parents or siblings should be redacted.

DHR and DHMH continue to be committed to ensuring that Section 2004 of the Affordable Care Act is implemented within the state of Maryland. Maryland has adopted the requirements and ensures that Medicaid covers any child under age 26 who:

- Was in foster care under the responsibility of the state when he or she turned 21
- Was enrolled in Medicaid under the state plan or waiver while in foster care
- Due to income or other criteria, does not qualify for Medicaid under another mandatory eligibility category (except for the category added by ACA to cover formerly ineligible adults under 65 with income up to 133 percent of the Federal Poverty Level.).

In Collaboration with DHMH, it was decided that local DSS staff could enroll transitioning youth into Maryland Health Connection prior to their 21st birthday. DHR has offered onsite technical assistance and sent directions to the LDSS' on how to complete this task. DHR will continue to ensure that youth are enrolled in health insurance upon exiting care.

DHR has a website for transition aged youth called MyLIFE, (<http://mdconnectmylife.org/>). The health care portion of the website has been updated to include all of the information for the connector entities across the state

(<http://mdconnectmylife.org/resources/health-care/>). This enables youth to access the site at any time and register into the Maryland Healthcare Connection to ensure health insurance until they are 26 years of age.

It is the caseworker's responsibility to discuss with the transitioning youth the importance of appointing a person to make healthcare decisions if the youth is incapacitated. In the State of Maryland, such a person is called a Health Care Agent. When developing the transitional plan with the youth, the caseworker does the following:

1. Describe a Health Care Agent and discuss the importance of appointing someone to make healthcare decisions should the youth become incapacitated;
2. Provide the youth with a copy of the Advance Directive for Selecting a Health Care Agent – <http://www.oag.state.md.us/Healthpol/infosheet.pdf>; and
3. Document in the Transitional Plan that the discussion took place and that the youth received a copy of the Advance Directive.

Health care planning for the transitioning or exiting youth is of utmost importance. DHR will continue to ensure that our youth are prepared and insured upon exiting foster care.

HEALTHCARE OVERSIGHT ADVISORY COMMITTEE

In determining appropriate medical treatment for children in Out-of-Home Placements, standards are outlined and described in Maryland's regulations (COMAR), The Maryland Healthy Kids/Early and Periodic Screening, Diagnosis, and Treatment (EPDST) Program. Standards for the Healthy Kids Program are developed through collaboration with key stakeholders, such as the Maryland Department of Health and Mental Hygiene (DHMH), Family Health Administration, the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School and the Maryland Department of the Environment. The components of EPDST represent the minimum pediatric health standards. The State of Maryland uses board certified physicians to provide medical services to children in foster care. DHMH is responsible for oversight of all physicians and the collection of medical data on each child and is working closely with the Department for implementation.

DHR has an organized Health Care Oversight Advisory Committee. The purpose of this team is to share information, provide recommendations, and to assure ongoing oversight and coordination of health care services for children who are in foster care. The Health Care Advisory Committee is a multidisciplinary team that will provide ongoing consultation regarding health care services (physical and mental health) for children and youth in Out-of-Home Placement. The Health Care Advisory Committee will also assist in the continuous development and improvement of a comprehensive system for children in Out-of-Home Placement.

PSYCHOTROPIC MEDICATION

Background Information

FEDERAL LAW IN REFERENCE TO OVERSIGHT AND MONITORING OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN IN FOSTER CARE

As part of the Child and Family Services Improvement and Innovations Act of 2011, states are required to amend their Title IV-B state plan to identify appropriate use and monitoring of psychotropic medications, as part of the state's current oversight of prescription medications. Section 422 (b)(15)(A)(ii) and (v) of the Social Security Act.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY (AACAP) POSITION STATEMENT ON OVERSIGHT OF PSYCHOTROPIC MEDICATION USE FOR CHILDREN IN STATE CUSTODY: A BEST PRACTICES GUIDELINE

The American Academy of Child & Adolescent Psychiatry (AACAP) is an organization consisting of professionals most skilled in the art and science of child psychopharmacology. Accordingly, the AACAP developed the following basic principles regarding the psychiatric and pharmacologic treatment of children in state custody:

1. Every youth in state custody should be screened and monitored for emotional and/or behavioral disorders. Youth with apparent emotional disturbances should have a comprehensive psychiatric evaluation. If indicated, a bio-psycho-social treatment plan should be developed.
2. Youth in state custody who require mental health services are entitled to continuity of care, effective case management, and longitudinal treatment planning.
3. Youth in state custody should have access to effective psychosocial, psychotherapeutic, and behavioral treatments, and, when indicated, pharmacotherapy.
4. Psychiatric treatment of children and adolescents requires a rational consent procedure. This is a two-staged process involving informed consent provided by a person or agency authorized by the state to act in loco parentis and assent from the youth.
5. Effective medication management requires careful identification of target symptoms at baseline, monitoring response to treatment, and screening for adverse effects

See the National Institute of Mental Health, List of Medications at <http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml> for a listing of psychotropic medications by trade, generic name, and drug classification.

The following information has been gathered by the AACAP to enhance practice and policy around psychotropic medication use.

Unique challenges of psychotropic treatment of youth in foster care:

- Up to 100% of youth may have experienced significant trauma
- Provider may not have access to early development or prior treatment history
- Medication consent may be provided by someone besides the parent
- Youth may experience disruptions in placement that lead to changes in treatment team

National data on psychotropic treatment of youth in foster care and Medicaid insured youth:

- Nearly 18% of youth in foster care receive a psychotropic medication compared with 6.2% of non-foster care Medicaid insured youth and 4.8% of private insured youth
- There was an estimated 62% increase in antipsychotic medication prescribing to Medicaid insured youth from 2002 – 2007
- Approximately 1/7 of antipsychotic medications prescribed to Medicaid insured youth had a diagnosis of ADHD-only
- 11% of Medicaid insured youth ages 3-5 years old prescribed antipsychotic medication had no psychiatric diagnosis

Predictors that a child in foster care will be prescribed a psychotropic medication:

- **Age:** Children in foster care are more likely to be prescribed psychotropic medications as they grow older. The likelihood of receiving multiple psychotropic medications also increases with age.
- **Gender:** Males in foster care are more likely to be receiving psychotropic medications (19.6 percent) than their female counterparts (7.7 percent).
- **Behavioral Concerns:** Children with behavioral problems, including internalizing and externalizing issues, are much more likely to be prescribed psychotropic drugs.
- **Placement Type:** The likelihood that a child will be taking any psychotropic medication tends to increase as placements become more restrictive. Eleven percent of children residing in In-Home settings receive psychotropic medications versus nearly 14 percent in foster care homes. In group or residential homes, where the behavioral and mental health needs of children are most severe, nearly half of the young people are taking at least one psychotropic drug. Additionally, children in more restrictive placement types are more likely to be taking multiple psychotropic medications.
- There are also significant geographic variations within and across States in the prevalence of psychotropic use among children in foster care, suggesting that factors other than clinical need may be influencing prescribing practices

Maryland State Agencies that Oversee Psychotropic Treatment of Youth in Foster Care

In Maryland, the authorization, oversight, and financing of psychotropic medications for children in foster care is directed through collaborative work by two state agencies. The Maryland Department of Human Resources (DHR) is the State's Child Welfare Agency.

As such, DHR is responsible for the consent and monitoring of psychotropic medication treatment of youth in foster care. The Maryland Department of Health and Mental Hygiene (DHMH) as the State's public health department is responsible for the health status of Maryland residents and ensuring access to quality health care. Within DHMH, two major administrations have responsibility for overseeing and financing psychotropic medications:

- Office of Health Care Financing- oversees Medicaid and the financing of psychotropic medications for all individuals enrolled in Medicaid, including children in foster care.
- The Behavioral Health Administration (BHA) is the State agency responsible for oversight and provision of mental health services to all individuals enrolled in Medicaid, including children in foster care.

The Psychopharmacology Monitoring Database

The Psychopharmacology Monitoring Database is an initiative by State leadership at BHA and Child Welfare. The database links administrative records from BHA (i.e. mental health claims) with child welfare data on youth in Out-of-Home Placement. This initiative has been ongoing since 2013 as a result of successful collaboration among the State child serving agencies and faculty at University of Maryland, Schools of Pharmacy and Medicine. The data linkage has been approved for statewide evaluation. There are recent efforts to work with jurisdictions to create linkages that would facilitate better monitoring at the direct patient care level. The evaluations that have been completed to date include: a) time trends in psychotropic use; b) antipsychotic persistence among very young children; c) use of concomitant antipsychotic treatment and the impact on hospitalization and emergency department use; and d) use of antipsychotic medication among children with attention-deficit/hyperactivity disorder (ADHD) with and without co morbidities. Evaluations currently in progress are: a) assessment of antipsychotic dosing in relation to hospitalization; and b) initiation of antipsychotic use and association with placement instability. This work has been presented at the 2013 Systems of Care Training Institute (SOCTI) and reports are periodically shared with the state administration. DHR has a current Memorandum of Agreement with DHMH / BHA and the University of Maryland (See Attachment 3, Attachment 4, and Attachment 5).

The department is exploring ways of using the data to improve current practice and policy. The current policy that DHR has regarding psychotropic medication, meets federal requirements. However, a workgroup was created in March 2016 with DHR, stakeholders, and community providers to review the data and make recommendations for practice.

Peer to Peer Program

The Peer Review Program for mental health medications (Also known as the Peer to Peer program) operates through the Maryland Medicaid Pharmacy Program. This program, which was implemented in October 2011, conducts pre-authorization review for antipsychotic medication treatment for youth that receive Medicaid. In January 2014, the program expanded to covering youth age 17 and younger. This program impacts all Medicaid enrolled youth, which includes all children in the Maryland foster care system. Providers are required to submit indication for medication treatment / target symptoms, baseline side effect assessment (e.g. Fasting blood work is required), information on referral for non-medication psychosocial treatments (e.g. Psychotherapy), the antipsychotic medication and dosage being requested, and a list of any co-prescribed medication. A review is conducted by a child psychiatrist before the medication is approved to be filled. An ongoing review of antipsychotic treatment is required every six months to assess if adequate safety monitoring and treatment response has been achieved to support ongoing medication treatment. In the case that a child is deemed to be at higher risk for side effects or where the drug regimen is unusual or complicated, an ongoing review may take place more frequently. DHR, in collaboration with DHMH / BHA and University of Maryland School of Medicine are exploring funding sources and ways to expand this program for foster children who are receiving any psychotropic medication.

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP)

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP) is a free statewide consultation, continuing education, and resource / referral program for pediatric primary care providers (PCPs) funded by the Maryland Department of Health and Mental Hygiene and the Maryland State Department of Education. B-HIPP supports the efforts of pediatric primary care providers in the assessment and management of mental health concerns among their patients through a consultation phone line. PCPs are able to have questions answered about diagnosis, medication, and other mental health and behavioral health concerns answered by child psychiatrists. B-HIPP is able to provide consultation to PCPs regarding children from infancy to transitional age youth, and their families. B-HIPP also seeks to increase access to children's mental health services by improving linkages between primary care providers and mental health treatment providers in the community. The clinical work for this project is carried out as collaboration among the University of Maryland School of Medicine / Department of Psychiatry, Johns Hopkins School of Public Health, and Salisbury University School of Social Work.

Oversight and Monitoring of Psychotropic Medications DHR Policy SSA-CW# 15-8

DHR is committed to ensuring oversight and monitoring of psychotropic medication use in foster children and youth. DHR has implemented the Oversight and Monitoring of Psychotropic Medications policy, which establishes guidelines for ongoing oversight and monitoring of prescribed psychotropic medications. The use of psychotropic medication

as part of a foster youth's comprehensive mental health treatment plan may be beneficial. The administration of psychotropic medications to youth is not an arbitrary decision and documented oversight is required to protect youth's health and well-being. Psychotropic medication must not be used as a method of discipline or control for any youth. Psychotropic medications are not to be used in lieu of or as substitute for identified psychosocial or behavioral interventions and supports required to meet a youth's mental health needs. DHR policy establishes guidelines to ensure proper oversight and monitoring of psychotropic medication that is prescribed to children and youth in out-of-home care.

WHO CAN PRESCRIBE PSYCHOTROPIC MEDICATION

A certified and licensed clinician is able to prescribe psychotropic medications to children and youth in foster care. If the prescribing clinician is not a child psychiatrist, consultation is required 60-90 days after initial prescription of the psychotropic medication to review the youth's clinical status to see if meaningful improvement is made within a time-frame that is appropriate for the youth's clinical response and the medication regimen used.

WHAT SHOULD HAPPEN PRIOR TO PRESCRIBING PSYCHOTROPIC MEDICATION

Prior to initiating each prescription for psychotropic medication the following must occur: The youth will have had:

1. A current physical and baseline laboratory workup.
2. A mental health assessment with a DSM-5 psychiatric diagnosis of the mental health disorder.
3. The prescribing clinician shall explain the purpose for and effects of the medication in a manner consistent with the individual's ability to understand (child, caregiver(s), and birth parent/legal guardian(s), if applicable). This explanation shall be documented in the case file by the caseworker and include the following:
 - a. The child/youth's mental health diagnosis.
 - b. All of the treatment options, which includes non-pharmacological and pharmacological.
 - c. The treatment expectations.
 - d. The potential side effects of the medication.
 - e. The risks and benefits of taking the medications versus not taking the medications.

GUIDELINES FOR ONGOING OVERSIGHT AND MONITORING OF PRESCRIBED PSYCHOTROPIC MEDICATIONS

Informed Consent

The Local Department of Social Services (LDSS) must have an informed consent for each psychotropic medication prescribed to a foster child. Informed consent is consent for treatment provided after an explanation of the proposed treatment, expected outcomes, side effects, and risk is provided by the prescribing clinician.

The DHR 631-IC, Psychotropic Medication Informed Consent form (See Attachment 6), is used to document the requirements. In an effort to assist the prescribing clinician to complete the informed consent, a sample letter explaining to the prescriber the need for an informed consent can be found in Appendix II of this policy. The letter can be presented to the prescriber prior to the appointment or at the time of the appointment.

The DHR 631-IC Psychotropic Medication Informed Consent form consists of four sections:

Section A: Psychotropic Medication Recommendation is completed by the prescriber and contains; the youth's identifying and clinical information, all current psychotropic medications, other medications (prescriptions and over the counter), new medications, recommendations including potential side effects, alternative treatments, and documentation of medication benefits/sides effects.

Section B: Notification is completed by the foster care worker prior to the doctor's visit.

Section C: Consent for Administration of Psychotropic Medication, is completed by the parent, legal guardian, or LDSS Directors (or their designee) who will either consent or deny consent. LDSS Directors and Assistant Directors may consent only pursuant to a court order as described below.

Section D: Consent -youth age 16 and older who are able to consent for their medication complete this section.

When a parent or guardian is unavailable or unwilling to provide consent and a child's prescribing professional has determined there is a medical necessity for the psychotropic medication, the LDSS must file a motion with the court requesting consent for the prescription and use of necessary psychotropic medication. Courts are provided authority for this action pursuant to Maryland Courts and Judicial Proceedings Section 3-824 (a). Foster parents and all other caregivers may not sign consent for psychotropic medications.

The caseworker must continue to communicate with the youth's parent or legal guardian regarding treatment when medication is not deemed a medical necessity, but there is a

DSM-5 psychiatric diagnosis supported by documented evidence/observations that medication would improve a child's well-being or ability to function.

Circumstances that may permit an exception for an informed consent for the prescribing of psychotropic medication include:

A child/youth entering foster care is currently taking psychotropic medication without a signed informed consent; every effort shall be made to obtain the DHR-631-IC within 30 days of entry into foster care. Psychotropic medication should not be discontinued abruptly unless it has been determined and documented as safe to do so by a prescribing clinician.

Caseworker's Role in Monitoring Psychotropic Medications

During the monthly home visit, the foster care caseworker reviews medication adherence and the medication's effect on the youth. At each home visit with a youth prescribed psychotropic medications, the following items must be discussed with both the caregiver and the youth:

1. A review of information that is provided by the prescribing clinician, about the intended effects and any side effects of the medication.
2. Compliance with all medical appointments, including dates of last and upcoming appointments with the prescribing clinician.
3. Medication availability, administration (i.e. is the youth compliant with medication schedule, is medication log being completed, etc.) and refill process.
4. Medication cannot be discontinued unless ordered by the practitioner.
5. Any and all adverse side-effects must be reported to both the prescribing clinician and foster care caseworker.

Documentation

Caseworkers document prescribed psychotropic medication and monthly discussions in MD CHESSIE contact notes. Also, the signed DHR-631-IC, Psychotropic Medication Informed Consent shall be filed within the medical section of the youth's case file.

The DHR/SSA 631 Health Passport contains all of the following:

- Mental Health Diagnosis,
- Name of prescribed psychotropic medications, dosage, and prescribing clinician's name and medical specialty,
- Routine medication monitoring appointments with prescribing physician,
- If applicable, ongoing testing/lab work specific for the prescribed medication,
- Any potential side-effects, and
- All non-pharmacological treatment services (i.e. therapy, behavioral supports/monitoring, and other interventions)

All items above are incorporated into the medical section of the youth's case service plan along with the following:

- The youth's physical reaction to the medication,
- Youth's comments and/or concerns regarding the medication,
- Caregiver's observations and comments regarding the effects of the medication,
- Feedback regarding the medication's effect on the child from birth parent(s), therapist, daycare providers, teachers and/or other persons as applicable, and
- All feedback (oral and written) from the prescribing clinician.

MD CHESSIE SCREENS

MEDICATION:

Service Cases > Dresser, Bridget (#20000521) > Clients > Dresser, Kristin (#20003603) > Health > Med-Alert

Examination | Chronic | Allergies/Sp. Needs/Hygiene/Phobias | **Medication** | Insurance

Info Provided Name	Relationship	Medication Name	Date Started
Bridget Dresser (1970-07-28)	2000 Daughter (Biological)	Lasix	01/09/2012

[Current Medications](#)

Medication Information

*Info Provided By

Client List: Collateral List:

Household Collateral

*Info Provided Name:

Relationship:

Medication Details

*Medication Name:

Dose/Frequency:

Date Started: Date to Stop: Date Stopped:

Reason/Purpose: [Edit](#)

Prescribed for because Kristin was diagnosed with high blood pressure. Medication help to maintain a normal blood pressure.

Physician Information

Physician Name:

Affiliation/Organization:

Address: [Edit](#)

Contact Info: [Edit](#)

Work: Ext:

Fax:

Pharmacy Information

Pharmacy Name:

Pharmacy Phone:

Comments: [Edit](#)

Medication is being monitored by Dr. Block and should be taken as prescribed.

The caseworker ensures that all medication information is entered into MD CHESSIE Medication screen. The LDSS supervisor provides oversight to ensure that the information is documented and correct. The caseworker ensures that all follow up appointments and re-evaluations are completed as recommended by the health care professional. The LDSS supervisor ensures that this documentation is completed in MD CHESSIE.

Training

DHR has partnered with the University of Maryland School of Medicine and the University of Maryland Child Welfare Academy and has created a standard training for child welfare staff on appropriate use of Psychotropic medication. This training will begin in spring 2016. This training will focus on using a trauma-informed approach to managing and overseeing the use of psychotropic medication in foster children.

DHR, in consultation with DHMH, University of Maryland School of Medicine, University of Maryland School of Pharmacy, and John Hopkins School of Medicine drafted psychotropic medication utilization guidelines for children and youth in foster care. The guidelines were developed with the goal of ensuring safe and appropriate psychotropic medication treatment for youth in foster care. Currently, the guidelines are still under review and will be released once the information is verified. DHR expects to release the guidelines in the fall of 2016.

Continuing to Reduce Psychotropic Medication Use

The policy as written, meets federal requirements for managing and monitoring the use of psychotropic medications for children in Out-of-Home care, as well as reflects some best practices that have emerged in recent years. However, the implementation of the policy at the local level has been challenging, as medical practitioners are reluctant to fill out the forms for the department and the department has no authority to require the practitioner to complete the forms. DHR recognizes that collaboration with DHMH is crucial to provide consistency throughout the state. Therefore, DHR is currently exploring ways to centralize the process for psychotropic medication monitoring and review.

Medicaid Demonstration

Addressing Over- Prescription of Psychotropic Medication for Foster Children is listed in the President's Budget (Source: Fiscal Year 2016 Budget of the US Government page 37 & 109.) The Budget establishes a new Medicaid demonstration project in partnership with the Administration for Children and Families to encourage States to provide evidence-based psycho-social interventions to address the behavioral and mental health needs of children and youth in foster care and reduce reliance on psychotropic medications with the goal of improving overall outcomes. Having access to funding to implement evidence based practices directly for children in foster care, would decrease the use of psychotropic medications. DHR will explore this opportunity when additional information becomes available.

CONCLUSION

DHR consistently evaluates the health care data and policy implementation. Since implementing the oversight policies for health care and psychotropic medication, the outcomes for foster children have improved. DHR will continue to recognize barriers and identify strategies to overcome presented barriers in order to ensure our youth receive the highest level of healthcare.

Please see annual updates for improvements to DHR's policies and practice.

ATTACHMENTS

Attachment 1 Maryland EPSDT Healthy Kids_2016 updates