MARYLAND DEPARTMENT OF HUMAN SERVICES

Social Services Administration

MARYLAND HEALTH CARE OVERSIGHT AND COORDINATION PLAN

2020 – 2024

TABLE OF CONTENTS

I. 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:

1. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
2. How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home;
3. How medical information will be updated and appropriately shared, which may include developing and implementing an electronic health record;
4. Steps to ensure continuity of health care services, which may include establishing a Medical home for every child in care;
5. The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;
6. 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
7. The procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses; and
8. Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.

This plan expands on the prior plan submitted as part of the 2015-2019 CFSP and updated annually to include lessons learned and planned improvements.

II. VISION FOR HEALTH CARE OVERSIGHT AND COORDINATION

Maryland is dedicated to the goal of all children receiving quality healthcare to meet their individual conditions and needs, including: routine wellness examinations and preventive care; health screenings; appropriate diagnosis, treatment and follow-up of somatic and behavioral health issues; and dental care. The Maryland Department of Human Services, Social Services Administration (DHS/SSA) works with this goal in mind to provide for coordinated, comprehensive, trauma-informed health care to children in foster care. DHS/SSA collaborates with other state agencies, non-governmental organizations and the medical and behavioral health community in order to achieve positive health outcomes for children and families in care. In this collaboration, it is essential to develop policies, activities and structures---based on collective stakeholder input, best evidence, and best practice---that not only support effective care delivery, oversight, and quality improvement, but integrate and respect our engaged families as well.

DHS/SSA has developed this Health Care Oversight and Coordination Plan that builds on work already being done in the State and embraces efforts of statewide partners and entities, such as the Maryland State Council on Child Abuse and Neglect and the DHS/SSA Health and Education Workgroup. DHS/SSA thanks the contributions from our partners and stakeholders in updating this plan and ensuring for the continued health care and oversight of the children and families in Maryland. See Appendix A for a full list of participants that provided input into the development of this plan.

III. ORGANIZATION OF HEALTH CARE OVERSIGHT

The oversight and coordination of health care services for children in foster care placement is guided by state and local regulations and policies and is a coordinated effort amongst various agencies serving children placed in foster care. The Maryland Department of Health (MDH) in collaboration with DHS/SSA ensures that children in foster care have access to appropriate and comprehensive health services. MDH's HealthChoice Managed Care Organization agreement establishes and identifies specific requirements, in accordance with Maryland state regulations, for certain special needs populations. Children under state supervision such as foster care are identified as a special needs population and upon entry into foster care a Managed Care Organization (MCO) is selected establishing a medical home and primary care physician for every child in care. The Managed Care Organization that the child is enrolled must provide or arrange to provide all Medicaid covered services and assure continuity and coordination of care locally. Each MCO must appoint a, "Special Needs Coordinator (SNC)" to provide support to Maryland's special needs population by coordinating and managing health services (medical and behavioral health). The manner in which these provisions are carried out may vary among MCO's to support the needs of children and youth in care as there is no "cookie cutter" approach

rather a managed care plan with complementary roles to enhance services and supports for children in care.

SSA, MDH, and MCO, Special Needs Coordinator work collectively to enhance the partnership identifying share outcomes and common measures for health services (medical and behavioral health) as well as strategies for sharing information to support effective treatment for children and youth. A cooperative collaboration at the state and local level to strengthen screening, assessment, and coordination of health services to appropriately case plan and monitor care is recognized across each service system to achieve positive outcomes.

In efforts to ensure the coordination and management of physical and behavioral health care needs for children and youth, the MCO/SNC and medical care team partner with Maryland LDSS's caseworkers and Maryland's Administrative Services Organization (ASO) Beacon Health Options to ensure the following:

- Coordinate with caseworkers and treatment providers (medical and behavioral health) as appropriate to ensure necessary health care needs and services received to address chronic health conditions and children with complex medical conditions requiring specialized case management services;
- Identify treatment resources and secure referrals, appointments, and admissions for children and youth;
- Support with information to facilitate medical placement as required or needed to the extent possible;
- Open line of communication to provide updated and essential health care information (child's medical and treatment history) to caseworkers assisting with the development of health care and case plans;
- Work closely with foster parent/s, caregiver, and/or biological parent to promote child/youth's well-being and decrease barriers to care;
- Participate in discharge planning and aftercare process to ensure continuity of care

Maryland Code of State Regulations

The Maryland Code of State Regulations (COMAR) 07.02.11.08 for the coordination of health care services for children in Out-of-Home Placement:

> A. The local department shall encourage the parents or legal guardian to participate to the extent of the parents' or legal guardian's capability and availability in plans for the medical care of any child committed to or in voluntary placement with the local department.

B. When the local department holds guardianship with the right to consent to adoption, the local department has the authority to give whatever consent is needed for medical care.

C. At the time a child is taken into care, the local department shall:

(1) Ask the parents or legal guardian to sign a document authorizing the local department to consent to:

(a) An initial health care screening;

(b) A comprehensive health assessment that meets the requirements of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program; and

(c) All routine and immediate medical care; and

(2) Seek medical guardianship from the court if the parents or legal guardian do not give consent, and, if the child is in need of immediate medical care, obtain treatment while consent is sought.

D. A local department caseworker or a law enforcement officer may take a child who may have been abused or neglected to a medical facility for examination and treatment without parental or legal guardian consent or court order, in accordance with Family Law Article, §5-712, Annotated Code of Maryland, and COMAR 07.02.07.07F.

E. The local department shall:

(1) Give notice to the child's parents or legal guardian before, and encourage participation in and attendance at, any planned evaluative, diagnostic, or inpatient medical care; and

(2) Promptly notify the parents or legal guardian of any treatment given without prior notice unless the notification violates the privacy rights of the child.

F. The local department shall document in the child's case record the actions taken by the local department to:

(1) Obtain medical consent;

(2) Involve the parents or legal guardian in decisions regarding the child's medical care; and

(3) Notify the parents or legal guardian of any medical care planned or given to their child.

G. Children in the custody or care of a local department shall be enrolled in Maryland's Medical Assistance Program.

H. If the child in an Out-of-Home Placement has private health care coverage, the private coverage shall be the primary source of coverage and Medical Assistance shall be the secondary source of coverage.

I. Initial health care screenings and comprehensive health examinations of children in the custody or care of a local department shall be provided by a primary care physician who is certified by the Maryland Healthy Kids Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

J. The local department shall secure an initial health care screening for a child in Out-of-Home Placement before placement or within 24 hours of placement, but not later than 5 working days following placement, except that a child who may have been abused shall receive immediate medical attention.

K. Within 10 working days of a child entering initial placement, the local department shall refer the child for a comprehensive health assessment. The local department shall ensure that every effort is made to secure the written assessment report by the 60th day of placement.

L. If the child's primary health care provider does not do the initial health assessment, the local department shall make the results of the comprehensive health assessment available to the child's primary health care provider or providers.

M. The primary care physician may make the professional decision to complete the initial and comprehensive health assessments at the same time, and shall forward all assessment results and any indicated follow-up to the local department.

N. Whenever health care needs are identified for a child in Out-of-Home Placement, the local department shall ensure that appropriate follow-up appointments are made for evaluation, diagnosis, and treatment to meet the child's health care needs.

O. The local department shall ensure that all children in Out-of-Home Placement follow the EPSDT schedule of preventive health care that includes screening components based on age from infancy through adolescence.

P. The local department shall schedule dental care for children 1 year old and older which shall include check-ups every 6 months and necessary dental treatment to be provided by the managed care organization or fee-for-service dental provider.

Q. All children in Out-of-Home Placement shall have a vision exam once a year in addition to any vision screening performed as part of the EPSDT exam.

R. The local department shall encourage adolescents 10 years old and older to openly discuss any questions and concerns with health care providers related to sexuality and reproductive health care.

S. The local department shall request:

(1) A substance abuse screening if the child's behavior or physical health indicates the likelihood of substance abuse; and

(2) A full-scale assessment of the child to address the child's treatment needs if the screening results indicate substance abuse.

T. The local department shall develop and use a health passport for each child in Out-of-Home Placement, which shall be kept current and accompany the child through the Out-of-Home Placement system.

U. The health passport shall include the following information:

(1) The identity of the medical facilities where the child usually receives care;

(2) The health care visit report on the child's condition at placement as documented by the child's physician;

(3) The child's immunization record, allergies/adverse reactions, chronic health problems, and present medications;

(4) Developmental status for a child younger than 4 years old, or for a child with a disability;

(5) Consents to health care and release of records; and

(6) Receipts for health care and release of records.

V. At the time of a child's placement, the local department shall provide the child's Out-of-Home Placement provider with the health passport, which has been completed to the extent possible.

W. The local department shall ensure that the child's case record contains the child's medical history and the most recent copies of the child's health care documents. When the documents are known to exist but have not been provided, the case record shall document efforts made to obtain them.

X. The local department shall use the child's private insurance and Medical Assistance card to obtain public mental health services for the child.

Y. The health passport shall be returned to the local department at the time the child leaves the placement.

Z. The local department shall provide the child who has exited Out-of-Home Placement with a copy of the child's personal health records at no cost when:

(1) The child is 18 to 21 years old and exits Out-of-Home Placement; or

(2) The child, who is younger than 18 years old at the time of exiting Out-of-Home Placement, becomes 18 years old and requests the child's personal health records

The Maryland Department of Health and Mental Hygiene and Medicaid Managed Care Organizations

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;
- Ensure a child in State-supervised care who moves shall be dis-enrolled from the recipient's MCO and enrolled in an alternative MCO if the recipient's current MCO does not serve the geographic region to which the child has been relocated.
- 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.

Maryland's MCO's providing health care services to children and youth in care include the following: Aetna Better Health Of Maryland, Amerigroup Community Care , Jai Medical Systems, Kaiser Permanente, Maryland Physicians Care, MedStar Family Choice, Priority Partners, UnitedHealthcare, and University of Maryland Health Partners.

Department of Human Services, Social Services Administration

DHS/SSA is responsible for providing State level oversight of Health Care Services including tracking health outcomes and collecting data on the timeliness and effectiveness of the provision of health care services for children placed in out-of-home care. Additional responsibilities include the development of a Centralized Health Care Monitoring Program for children in Out-of-Home Placement with the goal of ensuring children in care will receive optimal health care services. DHS/SSA develops and implements health care related policies to the Local Department of Social Services (LDSS), provides technical assistance and support to LDSS on health related matters and builds infrastructure that supports appropriate assessments and provisions of health care services, to include collaborating and consultation with the Maryland Department of Health Medicaid and other state and local experts in health care and child welfare services.

Local Department of Social Services

There are 24 Local Department of Social Services in Maryland. Each LDSS must comply with the Federal and State Oversight and Monitoring of Health Care Services Policies Some of the responsibilities of the LDSS include:

- Obtaining the signature of a parent or legal guardian to consent for health care related services.
- Enroll the child in the Maryland Medical Assistance Plan (MD-MA) as soon as possible after the initial placement.
- Coordinate health care services with the managed care organization (MCO) and obtain all medical history. This ensures a continuity of care and transfer of information between providers.
- Ensures initial health care screens, comprehensive assessments, annual well-child examinations, routine dental and vision exams and appropriate follow ups services are completed within the allotted time frame.
- Ensures appointments are scheduled and kept, referrals are made and follow ups are provided, needed evaluations, diagnosis, and treatments are secured to meet the child's health care needs.
- Provide local oversight and comply with guidelines to ensure proper oversight and monitoring of psychotropic medication that is prescribed to children and youth in out-of-home care.
- Ensures all documentation of health care needs and services are documented in Child Welfare electronic system.
- 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.

Please refer to Appendix C for Policy Directive 14-17, Oversight and Monitoring of Health Care Services and Appendix D for Policy Directive 15-18, Oversight and Monitoring of Psychotropic Medications for further details. SSA will begin the process of updating and reissuing both of these health related policies in 2020.

Making All The Children Healthy (MATCH) Program

Making All the 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 (HCAM). The MATCH program provides medical case management, health care coordination, education, and advocacy services to ensure Baltimore City children in foster care receive appropriate physical, dental and behavioral health care. The MATCH team is comprised of registered nurses, licensed social workers, non-licensed degree employees and administrative staff. These individuals collectively work to coordinate medical, dental and behavioral health exams for all children in foster care; review all medical documentation received; enroll children in the state's medical assistance program; case-manage children's complex behavioral and physical health needs; and assist young people in assuming the responsibility of managing their own health care when transitioning from foster care into independent adult lives.

Comprehensive health plans are developed with team input, as well as both resource parents and biological families as possible, allowing for the fortification of planning and the review of responsibilities in ensuring that appropriate health care is obtained and recommendations followed. MATCH incorporates a medical director for case review, quality improvement and BCDSS staff education and in-servicing as to relevant health topics and care considerations. The program also incorporates a consultant child psychiatrist for recommendations in the review of cases with complex psychiatric health needs and a pediatric medical director for recommendations in the review of medically complex cases.

Managed Care Organizations

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. MDH 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.

IV. Health Screening Schedule

Health Screenings Schedule (The Maryland Healthy Kids/EPSDT Program)

The Maryland Healthy Kids program promotes access to and ensures the 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 (Table 1) for Early Periodic Screening Diagnostic Treatment (EPSDT).

- **E**arly: Assessing and identifying problems early
- **P**eriodic: Checking children's health at periodic, age-appropriate interval
- **S**creening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **D**iagnostic: Performing diagnostic tests to follow up when a risk is identified, and
- **T**reatment: Control, correct or reduce health problems found.

EPSDT 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 makes any referrals as appropriate.

Table 1: Early Periodic Screening Diagnostic Treatment Schedule

Type of Exam	Description 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 the status of known chronic medical conditions. Recommendation for follow-up should include acute medical needs.
Comprehensive Medical Exam/EPSDT/ 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 EPSDT 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 EPSDT standards. Recommendations should include acute dental needs as well as routine dental follow-up.

Identifying, Treating, and Monitoring Health Care Needs

Children and youth involved with child welfare, especially those who are placed in out-of-home care, often present with complex and serious physical, behavioral health, developmental, and psychosocial problems rooted in trauma. Indeed, foster youth may benefit from a level of preventive health care beyond that routinely provided for the general pediatric population, including strategies to promote access to state-of-the-art interventions targeting modifiable risks for chronic health problems, such as high blood pressure, obesity and the complications of tobacco use. Medical care for children in foster care is often discontinuous, making it difficult for trusting patient–provider relationships to form and care to be delivered. Training and resources for caseworkers, resource parents, and group home staff, as well as biological families, emphasizing the importance of timely access, continuity and quality of health care provider relationships is vital.

Given these unique needs, DHS/SSA monitors the health needs of children in foster care through a variety of state and local efforts and cross-system collaborations. Each child who enters foster care is assigned a special needs coordinator from their assigned Managed Care Organization. The MCO provides or arranges 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 and ensures the continuity and coordination of care, serving as the child's Medical Home.

As per the SSA Oversight and Monitoring of Health Care Services policy, at the LDSS, caseworkers are responsible for collaborating with the MCO special needs coordinator and the child's foster parent or placement agency to ensure appropriate medical screening and exams are scheduled and kept as well as ensuring follow-up appointments and referrals are made and evaluations, diagnosis, and treatment services are secured to meet the child's health care needs. The LDSS is responsible for ensuring that the caregiver is aware of the child's health care and service needs.

In 2019, DHS hired The Child Welfare Medical Director. The Medical Director oversees the coordination and monitoring of health care services for children and youth receiving child welfare services. The director, in consultation with local departments of social services, will develop a Centralized Comprehensive Health Care Monitoring Program. The Medical Director is responsible for data collection on the timeliness and effectiveness of the provision or procurement of health care services for children in care, and tracking health outcomes for children in Out-of-Home Placements using the most recent Healthcare Effectiveness Data and Information Set (HEDIS) measures relevant to children including:

- Immunization status;
- Lead screening;
- Medical management of asthma;

- follow–up care for children prescribed ADHD medications;
- Depression screening and follow–up for adolescents;
- Antidepressant medication management;
- Follow-up after an emergency department visit or hospitalization for mental illness

The medical director has had discussions with expert partners at the University of Maryland and Johns Hopkins University regarding the use of other outcome and quality assurance measures, such as health status surveys (for example, the Child Health and Illness Profile and the Pediatric Symptom Checklist), in order to assess overall system impacts and provide for quality improvement.

DHS currently monitors efforts to address health and mental health by monitoring compliance of required health screens and exams and percentage of children who receive them within required time frame. Each month SSA conducts data analysis of health exam completions within each LDSS and provides the LDSS with a report and notice of cases out of compliance. The LDSS receives technical assistance and support to address barriers related compliance when needed. With the enhancement of the agency's new child welfare system, the agency will be able to conduct a more in-depth data analysis related to types of diagnosis, treatment needs and services. Over the course of the next five years, the agency plans to establish health outcome measures that are a better indicator of the effectiveness of health care services provided to children in care.

Maryland's DHS recognizes the persistent challenge of poor coordination and lack of communication between health providers, social services, caregivers and placement agencies involved in the child's care. Adequate and timely Information sharing, coordination of care, strengthening transition processes between placements and targeted training and skill building around coordination of health care services for children in state care for Child Welfare Staff and Health Care Provider are essential areas of priority over the next five years.

Informed 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, (DHS 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.

Additionally, the 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 DHS 631-IC, Psychotropic Medication Informed Consent form, is used to document the requirements and consent for all psychotropic medication prescribed to a foster child. 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 is provided; the letter can be presented to the prescriber prior to the appointment or at the time of the appointment.

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 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.

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.

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.

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 the regiment.
- 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.

Appendix E. contains more detail on minor consent.

V. UPDATING AND SHARING MEDICAL 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 MCO's are the guardians of this information and over the course of the next five years, the agency plans to strengthen collaboration between the LDSS and MCOs to allow for the ability to engage in bi-directional communication to ensure the historical data and current status of the child is discussed so appropriate referrals are made. For continuity of care, the MCO should attempt to contact the child's previous MCO to inquire about medical history etc.

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 any time 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.

The agency plans to explore the possibility of data sharing agreements in which Electronic Medical Records (EMR) is able to link with the new Child Juvenile Adult Management System (CJAMS) so that information can be transmitted electronically. In addition, the agency will explore feasibility of data sharing from The Chesapeake Regional Information System for Our Patients (CRISP) and claims data from Medicaid to Maryland Total Human Services Information Network (MDTHINK). This is a huge undertaking for the agency as it requires the authorization of multiple agencies and governing structures and HIPAA compliance.

DHS recognizes that there is great opportunity to provide training on best practice strategies and support around accessing, updating and sharing medical information, appropriate documentation and appropriately detailing medical information between placements and caregivers. These trainings and supports will be targeted to others involved in the medical care of children in foster care beyond the health care providers such as caseworkers, foster parents and placement agency staff.

Health Passport

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 Health Passport is a series of documents that:

- 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.
- Serves as the caseworker's documentation for compliance purposes.
- Serves as a record that provides health care documentation and historical data for children who are adopted or who are permanently separated from their families.

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 age 18, as appropriate, and at no cost.

As part of DHS's modernization efforts, the agency will explore the feasibility of establishing an electronic health passport and portal to improve accessibility and sharing of information for families and providers who care for the child.

Currently, the child's health needs and treatment are 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.

Currently, the child's health needs and treatment are documented in the health screens of the agency's child welfare system MD CHESSIE. 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 includes 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.

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

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

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

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

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

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

In late 2019, DHS will begin using the Child Juvenile Adult Management System (CJAMS). CJAMS will replace the current MD CHESSIE system. The development of CJAMS has been a collaborative process to ensure that the agency is fully able to capture the health needs and services of children and youth in care. The system is designed to support case workers and staff in entering and uploading health related information. The new system will also allow for improved monitoring of health related needs and services at both the state and local level. The system is currently under development and over the next 5 years, the agency anticipates that the implementation of CJAMS will improve monitoring and coordination of healthcare related services. Please see yearly updates to the agency Health Care Oversight and Coordination Plan for further progress and development of CJAMS.

VI. CONTINUITY OF HEALTH CARE SERVICES

Establishing continuity of care and ensuring a trauma-informed comprehensive and coordinated treatment approach by all professionals involved is a priority for DHS/SSA. The exchange of health and treatment information between providers and the provision of information to families and caregivers, whether through DHS/SSA or directly by health insurance providers, is critical. Currently, if the child has a primary care provider (PCP) 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 PCP, 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. Caseworkers will also communicate directly with health care providers and caregivers in those efforts.

To support care and continuity, MCOs utilize special needs coordinators, positions mandated by state regulations to who serve as "point(s) of contact for health care services information and referral for members of special needs populations", which include children in state-supervised care. Ideally, special needs coordinators work with DHS/SSA caseworkers to discuss historical health care usage (including compliance with a given PCP), gaps in care and the current needs of the child and offer related assistance. MCOs' routinely receive the names of children in out-of-home care, but will not have the associated case workers. Improvements in communication between DHS/SSA and the MCOs are being examined to increase information sharing between the agency and MCOs, as well as between MCOs, as children may be assigned to different organizations over time, each which are the guardians of their own collected medical data. DHS/SSA is assessing the feasibility of establishing an electronic means by which providers can have access to and provider patient health information and caregivers, case workers and care managers may access current health data; this sort of electronic health passport/portal has models in various states and will require the resources and collaborative efforts of MCOs, state agencies, and the region's health information exchange, CRISP or Chesapeake Regional Information System for our Patients. CRISP allows for the provision of alert messaging to registered providers of patient movement through the healthcare system, such as with emergency department visits or step downs from intensive care. This messaging capability may be utilized to alleviate the issue of PCPs being unaware when their patients enter or exit foster care, allowing for more timely communication with local child welfare supports and improving care and continuity. DHS/SSA is also exploring means for statewide central health care coordination, including an expansion of the BCDSS MATCH program, which will improve care planning, caregiver inclusion, and continuity of care; discussions with local academic institutions about a limited pilot have been initiated.

VII. OVERSIGHT OF PRESCRIPTION MEDICATIONS

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 Services, Social Services Administration (DHS/SSA) as the State's child welfare agency and the Maryland Department of Health (MDH) as the State's public health department.

DHS/SSA is responsible for the consent and monitoring of psychotropic medication treatment of youth in foster care while DOH 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.

SCREENING, ASSESSMENT, AND TREATMENT PLANNING

Over the next five years, in order to identify needs for psychotropic medications for children and youth, the agency plans to collaborate with the current mental and somatic healthcare partners to put into place comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma- treatment needs. This will include psychiatric evaluations for children and youth, as necessary and an assessment for risk of non-adherence to medication.

In current DHS/SSA policy, prior to initiating each prescription for psychotropic medication the following must occur. The youth will have had

- A current physical and baseline laboratory workup.
- A mental health assessment with a DSM-5 psychiatric diagnosis of the mental health disorder.
- The prescribing clinician shall explain the purpose 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.

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 or target symptoms, laboratory values for metabolic screening, (e.g. blood glucose work is required), information on referral for non-medication

psychosocial treatments (e.g. Psychotherapy), an antipsychotic medication and dosage being requested, and a list of any co-prescribed medication. A review is conducted by a psychiatric pharmacist, and when necessary 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 of the clinical condition support ongoing 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. DHS/SSA, in collaboration with MDH/BHA, and University of Maryland School of Medicine continue to explore funding sources and ways to expand this program for foster children who are receiving any psychotropic medication.

SSA has in place informed and shared decision making processes and methods for ongoing communication between the prescriber, the child, the child's caregivers, and other stakeholders (e.g., healthcare providers and child welfare worker). This involves ensuring there is clear documentation, sharing, and understanding of information on any adverse effects of medication with the child and the child's caregivers and clear documentation and understanding of the medication use including the starting dose and timing of dose changes in the medication list is critical. This documentation will be captured through the following mechanisms.

MEDICATION MONITORING

To ensure effective psychotropic medication monitoring at both the client level and agency level for children and youth in in-home or out-of-home foster care, the following monitoring activities are in place.

A certified and licensed clinician prescribes 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 the initial prescription of 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.

The LDSS worker ensures that all follow up appointments and re-evaluations with the child or youth's healthcare provider(s) are completed as recommended by a healthcare professional. The LDSS supervisor ensures that this documentation is completed and data entered into the child welfare integrated data system. Furthermore, during monthly home visits with the child/youth and caregiver, the 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 are discussed with both the caregiver and the youth:

- A review of information that is provided by the prescribing clinician, about the intended effects and any side effects of the medication.
- Compliance with all medical appointments, including dates of last and upcoming appointments with the prescribing clinician.
- Medication availability, administration (i.e. is the youth compliant with medication schedule, is medication log being completed, etc.) and refill process.
- Medication cannot be discontinued unless ordered by the practitioner.

- Any and all adverse side-effects must be reported to both the prescribing clinician and foster care caseworker.

MENTAL HEALTH EXPERTISE

In 2019 DHS appointed a Medical Director to support the oversight and monitoring of psychotropic medications. DHS/SSA is building stronger partnerships with faculty at the University of Maryland, Schools of Pharmacy and Medicine. These partnerships will further engage mental health experts regarding any consent or monitoring issues for the use of psychotropic medication for children and youth in care.

INFORMATION SHARING

DHS/SSA has in place mechanisms for sharing accurate and up-to-date information related to psychotropic medications with clinicians, child welfare staff, and consumers (e.g., children, youth, and caregivers), including both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials. These processes include:

- All medication information is entered into SSA's child welfare integrated data system into the Medication or health section by the caseworker. The LDSS supervisor provides the oversight necessary to ensure that the information is documented and entered correctly and timely.
- Caseworkers document all prescribed psychotropic medication and monthly discussions in their contact notes in SSA's child welfare integrated data system. Also, the signed DHR-631-IC, Psychotropic Medication Informed Consent, is filed within the medical section of the youth's case file.
- The DHR/SSA 631 Health Passport (detailed above) contains up-to-date information on the child or youth's mental health diagnosis, names of all prescribed psychotropic medications, routine medication monitoring appointments with prescribing physician, and all non-pharmacological treatment services.

DHS/SSA will be exploring ways of using available data from the University of Maryland, School of Pharmacy to improve and enhance current practice and policy at the LDSS level. To this end, the service array workgroup that is comprised of DHS/LDSS staff, stakeholders, and community providers will be providing feedback and make recommendations for practice and policy.

TRAINING

DHS/SSA has partnered with the University of Maryland, School of Medicine and the University of Maryland Child Welfare Academy to create a standard training for child welfare staff on appropriate use of Psychotropic medication. This training began in spring 2016 and focuses on using a trauma-informed approach to managing and overseeing the use of psychotropic medication for children and youth in foster children.

CONTINUING TO REDUCE PSYCHOTROPIC MEDICATION USE

DHS/SSA's current policy regarding the oversight and monitoring psychotropic medication for children and youth in out-of-home care meets federal requirements and reflects 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 required forms for DHS/SSA and DHS/SSA has no authority to require practitioners to complete these forms. DHS/SSA recognizes that collaboration with the Department of Health is crucial to provide consistency throughout the state. With the implementation of the Medical Director, the agency anticipates making progress with improved collaboration with the Department of Health.

DHS/SSA is currently in the process of updating the contract with the University of Maryland, School of Pharmacy around psychotropic medication. Apart of this contract renewal includes improved reporting of the data which will allow the LDSS to make informed decisions. The renewed contract will also include a provision requiring the School of Pharmacy Physician to speak and present the psychotropic medication use data to the LDSS staff as well as the state lead implementation teams in consultation with Child Welfare Medical Director. This effort is aimed to provide additional support and guidance to the LDSS for the children in their care.

VIII. CONSULTATION AND INVOLVEMENT OF PROFESSIONALS IN ASSESSING AND TREATING CHILDREN

Maryland House Bill 1582 "Centralized Comprehensive Health Care Monitoring Program", passed in May 2018, required DHS to hire a State Medical Director to oversee the coordination and monitoring of health care services for children in the custody of local departments of social services. Hired in 2019, the Director is responsible for the general assessment, assurance and improvement of the state's system for health care provision (including the domains of process, adequacy, appropriateness [cultural competency, trauma informed care provision, etc.], and outcome), hewing closely to Child Welfare League of America's *Standards of Excellence for Health Care Services for Children in Out-of- Home Care*. As part of this work, the medical director is also responsible for the development of a health service monitoring program that ensures centralized health care coordination. The medical director is planning for the formation of a working group of pediatric medical providers, including those providing trauma-informed behavioral health services, and relevant stakeholders. The group will meet on a routine schedule to review and discuss statewide systemic diagnosis and treatment issues.

On an individual basis, MCOs engage special needs coordinators and medical case managers, as appropriate, to assure care coordination; local caseworkers maintain communication with these entities and health care providers as part of monitoring and oversight. Also, the role of the state medical director includes availability for consultation with LDSS in order to review cases and assure access to medical experts, as necessary, to support appropriate assessment and treatment planning. Lastly, the BCDSS MATCH program offers DHS/SSA insight into the potential utility and effectiveness of local/regional nurse case management within a child welfare setting; the agency will be exploring those options as it meets its legislative mandate.

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 a 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.

IX. PREVENTING INAPPROPRIATE DIAGNOSIS

DHS/SSA has developed a multi-faceted approach to preventing inappropriate diagnoses of children in foster care. Maryland's approach is designed to understand the potential for misdiagnosis through research and analytics; collaborate with multiple stakeholders who play a role in diagnosis; develop practice interventions and protocols and provide relevant training and coaching in support of behaviors that will avoid misdiagnosis; and, institute oversight and continuous quality improvement to ensure that there is reinforcement of successful strategies to prevent misdiagnosis and attention to areas of concern. This plan is intended to be evolving; elements of the plan intentionally build on one another as Maryland's collective understanding of diagnosis and misdiagnosis grows and we learn from what works over time.

Research and Analytics. DHS/SSA plans to partner with the Maryland Department of Health and research and university partners to conduct the following kinds of analysis, on at least an annual basis, to form an empirically informed picture of children at risk of misdiagnosis:

- Analysis to describe the volume and characteristics (age, placement type, length of stay) of children diagnosed with the referenced conditions in the foster care population.
- Comparative and comparative and trend analysis on children with diagnosis, including jurisdictional and regional trends.
- Literature review and scan of population reference data to understand the prevalence and characteristics for these conditions in the child welfare and general population.
- Identify outliers and hot spots to flag potential misdiagnoses for additional oversight and strategy development.

Collaboration. DHS/SSA seeks to engage system partners in identifying the potential for misdiagnosis and in supporting strategies that will prevent misdiagnosis from occurring. Building on the research and analytics, DHS/SSA will engage in data informed discussions partners as a starting point, to make meaning of the data together and identify shared priority strategies for action. The initial plans are to explore:

- Engaging with medical and resource homes to highlight how appropriate behavior management techniques can support preventing inappropriate diagnosis.
- Developing a standardized memorandum of understanding with MCO to clarify roles and responsibilities with regard to overseeing diagnoses.
- Sharing data with LDSS Local Care Teams and determining additional opportunities to collaborate on providing resources for children with intensive needs that may avoid inappropriate diagnosis and placements.
- Collaborating with outpatient programs, hospitals, counseling programs and other related providers, to ensure consistent and timely sharing of documentation of diagnosis information with LDSS, which will aid in timely decision-making on second opinions, as needed.
- Sharing information on inappropriate diagnosis with Maryland State Department of Education and Local Education Agency (LEA) school health programs.

Practice Interventions and Protocols. As DHS/SSA continues to refine and develop tools in support of the Integrated Practice Model, we will build in clarification of how specific practice interventions should be used in support of preventing inappropriate diagnosis and provide specific protocols. This includes:

- Refining practice profiles related to assessment and planning to include desired worker behaviors in support of accurate assessment and meaningful engagement and follow-up with parents, foster parents and medical providers related to diagnosis.
- Developing protocols to discuss, address and assess information about diagnosis and child placement with families, their supports and other stakeholders during family involvement meetings or other team decision-meetings.
- Develop partnerships to obtain medical consultation on diagnosis, exploring protocols for obtaining proactive medical consultation or second opinions for certain children (as informed by analytics), and defining benchmarks for revisiting a diagnosis over time.

Workforce Development and Training. In support of the aforementioned practice interventions and protocols, DHS/SSA intends to engage in transfer of learning to ensure that staff and foster parents develop skills and capacity in support of preventing inappropriate diagnosis. Such efforts will include:

- Collaborating with the Child Welfare Academy to develop trainings for the child welfare workforce (staff and supervisors) around responding to physical, developmental and behavioral health diagnosis of children in care.
- Developing and implementing training on the plan to prevent inappropriate diagnosis and the practice protocols implemented; including internal and external workers and in pre-service and ongoing training.
- Exploring opportunities to develop and offer training for foster parents about their role as informed and active participants in a child's health care, including their role in providing information to medical providers and case workers related to presenting child conditions.

Oversight and CQI. A fundamental and overarching element of the plan will be to ensure that there is appropriate oversight and ongoing continuous quality improvement to assess the implementation and impact of the plan's components. DHS/SSA's Child Welfare Medical Director, will work in concert with the Child and Family Well-Being unit and the Continuous Quality Improvement team to provide ongoing best practices information and technical assistance to local departments regarding diagnosis and placement. The Medical Director will also facilitate and inform the development of local protocols for medical consultation and ongoing local oversight to prevent inappropriate diagnosis.

X. HEALTH INFORMATION FOR TRANSITIONING YOUTH EXITING CARE

According to the Fostering Connections to Success and Increasing Adoptions Act of 2008, all states are required to assist and support youth in developing a transition plan as he/she ages out of foster care. The State of Maryland has developed the Maryland Youth Transition Plan (YTP) to comply with this mandate and has enhanced the plan to include most recent provisions of the Family First Prevention Services Act of 2018. The purpose of the YTP is to ensure youth obtain the resources and skills needed to be self-sufficient. The YTP is the tool used by the Department of Social Services (LDSS) in conjunction with the youth which empowers the youth to plan for their future. The plan outlines transition goals that encompass education, employment, financial empowerment, permanent and supportive connections, well-being, and civic engagement. Youth participate in the YTP process beginning at age 14 and continue to review and revise the plan every 6 months. Ninety days prior to a youth's 18th birthday the YTP is finalized.

The LDSS shall provide the child who has exited Out-of-Home Placement (OHP) documents including a Foster Care Verification Letter, Education Records, Social Security Card, Birth Certificate, Maryland State Photo Identification, Medical/ Health Insurance Card, Medical Records all at no cost when the child exits by attainment of age or the child exits prior to age 21.

- 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.

DHS/SSA and MDH 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 years who:

- Was receiving state foster care services and enrolled in Medicaid under the state plan or waiver on his or her 18th birthday; or
- Have a household income less than 138% of the Federal Poverty Level.

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

DHS/SSA 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 Maryland Advance Directive: Planning for Future Health Care Decisions and discuss the process for Selecting a Health Care Agent – http://www.marylandattorneygeneral.gov/Health%20Policy%20Documents/adirective.pdf;
3. Document in the Transitional Plan that the discussion took place and that the youth received a copy of the Advance Directive; and
4. Provide guidance and support to the youth if they decide to create an Advance Directive and assist the youth in identifying whom the youth is connected to for sharing the Advance Directive.

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

XI. LESSONS LEARNED

Since the development of the prior Health Care Oversight and Coordination Plan, DHS, SSA has learned that in order to efficiently monitor and meet the health needs of children in child welfare, increased coordination and collaboration with other agencies and programs serving the same population is crucial. Maryland is rich in health resources for children, however much of the work is in silo. Although DHS is responsible for the children in out of home care, the health and health related services of these children is the responsibility of many systems and each entity should improve the collaboration and coordination of services to ensure children have the best health outcomes as possible.

In addition to increased collaboration and coordination, the agency has realized the importance of having medical expertise in house, thus the implementation of the Child Welfare Medical Director. The agency has also learned that targeted training around and support around coordination of healthcare services is crucial to the child welfare workforce. DHS/SSA has learned that caseworkers and supervisors are not always aware of who they need to connect with and how that happens. With the enhanced collaboration and coordination with MDH and other external agencies providing health services to children, implementation of the Medical Director and health related training and support to the child welfare workforce, the agency anticipates progression in the health oversight and outcomes of children in care.

XII. DATA AND OTHER MEASURES TO DETERMINE COMPLIANCE

DHS/SSA recognizes in order to achieve positive outcomes and strengthen the well-being for infants, children and youth in foster care depends largely on establishing measures that are accurate indicators of children receiving quality services and supports to meet their needs. The agency looks at several measures and tools to document compliance of healthcare related policies and procedures.

The agency will utilize the performance on the Well-Being Headline Indicator measures related to requirements for the initial, comprehensive, annual and dental health assessments to assess compliance of state policies and procedures. See Table 1 for yearly targets of measure

Table 1: Health Related Well-Being Headline Indicators and Yearly Targets

Headline Measure	**Percentage as of December 2018**	**Year 1 Target**	**Year 2 Target**	**Year 3 Target**	**Year 4 Target**	**Year 5 Target**
% of Initial Health Assessment completed within 5 days	59%	61%	63%	65%	66%	67%
% with a comprehensive assessment completed within 60 days	91%	92%	93%	94%	95%	96%
% with an annual health assessment completed within 1 year	71%	73%	75%	77%	78%	79%
% with a dental assessment completed within 1 year.	55%	57%	59%	61%	63%	64%

The agency will also continue to utilize health monitoring as a tool to assess compliance with state policies and procedures. The agency utilizes the Out-Of-Home Milestone report as a tool to monitor and provide oversight of compliance. The milestone report indicates which LDSS are out of compliance with health requirements as it relates to timely health exams. The agency currently reviews the percentage of cases out of compliance during monthly health monitoring. As a result, each month, the LDSS receive email notification identifying areas of concern for the LDSS to address and resolve within an identified time. In addition, the agency conducts monitoring through quarterly random sampling of cases which serves as a "deeper dive" into the case record to monitor compliance of health requirements including reviewing of documentation related to health services. Technical assistance is provided to each LDSS at this time. DHS/SSA's monitoring and Technical Assistance (TA) will provide in-person presentations, conference calls with LDSS leadership and one-on-one consultation to address data trends, issues of concern, and resolve specific case related matters to determine compliance and health outcomes.

The agency will utilize the Child and Family Service Reviews (CFSR) and the Well-Being Outcome 3 measures; the agency's ability to address the physical, mental and behavioral health needs of the children to assess the agency's progress, inform the Health Care Plan activities and priorities for intervention from year to year.

CFSR Case Reviews and Stakeholder interviews revealed that current assessments are inaccurate and often disconnected to the service planning needed to appropriately to ensure that children receive adequate physical and mental health needs. This item is being addressed in the Child and Family Service Plan Goal 2; engage in a collaborative assessment and planning process that is inclusive of formal and informal community partners.

The agency is currently providing opportunities to LDSS staff to strengthen the administering of The Child and Adolescent Needs and Strengths (CANS) assessment how to better utilize the tool to support decisions and service planning. With accurate and consistent administering of the CANS, the agency will be able to better utilize the CANS Headline Indicator data measures related to physical health, developmental, behavioral, emotional health needs and trauma experiences to assess progress on service plan and adequate service delivery.

The agency with the support of its TA partners has begun exploring the use of CANS data to establish a Well-Being metric. The Well-Being metric is a formula that utilizes the CANS data of identified needs at intake, developed needs during time in care and needs that were resolved to indicate a Well-Being metric number. This formula is still being developed and vetted for validity and accuracy as the data is largely dependent on the accurate administering of the CANS assessment at the LDSS.

With the implementation of CJAMS and an enhancement of the Health Profile, over the next five years, the agency anticipates an increase in available and more accurate data around health services for children in care. CJAMS will allow the agency to look at additional health related data from both a local and state perspective which will allow for targeted interventions as it relates to monitoring of compliance.

Lastly, DHS/SSA plans to collaborate with the Maryland Department of Health (MDH) Managed Care Organization (MCO) Special Needs Coordinators to establish agreed upon health measures that provide a better indicator of health related outcomes The goal is to explore what data metrics or tools can be utilize data ensure health needs of children and youth in care are being adequately addressed. Collaborative efforts with MDH and MCO's around data sharing of information such as health assessments, case plans, and HEDIS scores will enhance DHS/SSA's ability to effectively determine if children and youth are receiving adequate health services and strengthening the overall well-being.

Please see annual updates for improvements and changes related to DHS's Health Care Oversight and Coordination Plan.

APPENDIX A: Contribution from agencies, participants and stakeholders

The following agency representatives provided input into the development of this plan.

Agency/Stakeholder	Participant
Anthem Amerigroup, Inc.	Maria Rybak, LCSW-C Program Manager, Specialty Products
Kennedy Krieger SHNIC program, specialized health needs	Barbara Obst, RN
Maryland State Department of Education, Health Services Specialist	Alicia Mezu, RN
Local Department of Social Services	Beverly McDermott and Wendy Lane
State Council on Child Abuse & Neglect	Claudia Remington
Child Maltreatment Pediatrician, C.H.A.M.P member	Wendy Grier
Advocates for Children and Youth Public Justice Center	Rachel White
Beacon Health Options	Jay Hensley, RN (MCO Nurse Liaison)
Maryland Medicaid MCO, Kaiser Permanent of the Mid-Atlantic States	Miryan Machado, LCSW-C Special Needs Coordinator
Maryland Medicaid MCO, Amerigroup, Inc.	Anna Matheus, LCSW-C, MCO State Liaison and Special Needs Coordinator
United Healthcare Community & State Maryland	Brenda McQuay, Special Needs Coordinator
University of Maryland Baltimore, School of Pharmacy	Dr. Susan DosReis
Making All The Children Healthy (MATCH) Program	Kenya Johnson, MPA Kimberly Floyd

APPENDIX B: 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.

APPENDIX C: Oversight and Monitoring of Healthcare Services Policy (Excerpt)

On April 15, 2014, DHS 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.
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 five 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 the state automated data system. Any paper documents are scanned into the state automated data system.

APPENDIX D: Oversight and Monitoring of Psychotropic Medications Policy (Excerpt)

On October 15, 2014, DHS issued a policy, SSA-CW #15-8 Oversight and Monitoring of Psychotropic Medications, to ensure proper oversight and monitoring of psychotropic medication that is prescribed to children and youth in out-of-home care. The Oversight and Monitoring of Psychotropic Medications policy 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 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 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, is used to document the requirements. 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 (prescription and over the counter), new medications, recommendations including potential side effects, alternative treatments, and documentation of medication benefits/side 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 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.

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 a healthcare professional. The LDSS supervisor ensures that this documentation is completed in MD CHESSIE.

APPENDIX E: Health Care Services Consent for a Minor

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	A minor *(i.e. person under the age of 18)* has the same capacity as an adult to consent to medical or dental treatment if the minor: 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. [Md. Code Ann., Health-Gen II §20-102(a)]	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)]
Pregnancy	A minor *(i.e. a person under the age of age 18*) 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.e. a person under the age of 18)* 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.e. a person under the age of 18)* 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.e., a person under the age of 18)* 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 an abortion [Md. Code Ann., Health-Gen II § 20-102(f)]
Abortion	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)]	*Waiver of Notice*- No notice required, if, in the professional judgment of the physician: 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. *Incomplete Notice*-No notice required if: 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. [Md. Code Ann., Health-Gen. II § 20-

		103(b)] 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)] *Notice Prohibited*- 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)]
Emergency Medical Services	A minor *(i.e. a person under the age of 18*) 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. [Md. Code Ann., Health-Gen. II § 20-102(b)	The health care provider shall inform the minor's parent or guardian. 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. [Md. Code Ann., Health-Gen. II § 5-607]
Drug and Alcohol Abuse Treatment	A minor (i.e., a person under the age of 18) 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)] *Psychological treatment for drug abuse or alcoholism* 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	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)]

	minor would be affected adversely by delaying treatment to obtain the consent of another individual [Md. Code Ann., Health-Gen . II § 20-102 (d)] *Refusal of treatment* 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)]	
Outpatient Mental Health Services	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	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)]
Sexual Assault and Rape Services	A minor *(i.e., a person under the age of 18)* has the same capacity as an adult to consent to: · Physical examination and treatment of injuries · Physical examination to obtain evidence from an alleged rape or sexual offense. [Md. Code Ann., Health-Gen. II § 20-102 (c)(6)-(7)]	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)]

Admission to Detention Center	A minor (i.e. a person under the age of 18) has the same capacity as an adult to consent to: · Initial medical screening and physical examination on and after admission into a detention center [Md. Code Ann., Health-Gen. II § 20-102 (c)(8)	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)]

APPENDIX F: Maryland Healthy Kids Preventive Health Schedule; EPSTD schedule

Maryland Healthy Kids Preventive Health Schedule

Components		Infancy (months)							Early Childhood (months)							Late Childhood (yrs)						Adolescence (yrs)								
Health History and Development		Birth	3-5 d	1	2	4	6	9	12	15	18	24	30	36	48	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19/20
Medical and family history/update		X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peri-natal history		X	X	X	→	→	→	→	→	→	→																			
Psycho-social/environmental assessment/update		X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Surveillance (Subjective)			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Screening (Standard Tools)[1]								X	→	→	X	X	→																	
Autism Screening											X	X	→																	
Mental health/behavioral assessment														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance abuse assessment																						X	X	X	X	X	X	X	X	X
Depression Screening																						X	X	X	X	X	X	X	X	X
Physical Exam																														
Systems exam		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vision/hearing assessments[2]		O[2]	S	S	S	S	S	S	S	S	S	S	S	S/O	S/O	S/O	S/O	S	S/O	S	S/O	S	S/O	S	S	S/O	S	S	S/O	S
Oral/dentition assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing:	Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Head Circumference	X	X	X	X	X	X	X	X	X	X	X																		
	BMI											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure[3]														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Risk Assessments by Questionnaire																														
Maternal Depression Screening				X	X	X	X																							
Lead assessment by questionnaire							X	X	X	X	X	X	X	X	X	X														
Tuberculosis *				X	→	→	X	→	X	→	→	X	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Heart disease/cholesterol *												X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sexually transmitted infections (STI) *																						X	X	X	X	X	X	X	X	X
Anemia *																						X	X	X	X	X	X	X	X	X
Laboratory Tests																														
Newborn Metabolic Screening		X		X	→																									
Blood lead Test									X	→	→	X	→	→	→	→														
Anemia Hgb/Hct									X	→	→	X	→	→	→	→														
Dyslipidemia Test																				X	→	→							X	→
HIV Test																										X	→	→	→	
Immunizations																														
History of immunizations		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vaccines given per schedule		X	→	→	X	X	X	→	X	X	X	→	→	→	→	→	→	→	→	→	→	X	X	→	→	→	→	→	→	→
Fluoride Varnish Program[4]								X	X	X	X	X	X	X	X	X														
Health Education																														
Age-appropriate education/guidance		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counsel/referral for identified problems		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental education/referral									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Scheduled return visit		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Key : X Recommended; → Recommended if not previously done; S Subjective by history/observation; O Objective by standardized testing; * Counseling/testing recommended when positive

The Schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly preventive care visits between ages 3 years through 20 years. [1]Refer to AAP 2006 Policy Statement referenced in the Healthy Kids Program Manual.-Screening required using standardized tools. [2]Newborn Hearing Screen follow-up recommended for abnormal results. [3]Blood Pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years. [4]The fluoride varnish may be administered by either a primary care provider or a dentist.

http://mmcp.dhmh.maryland.gov/epsdt *Healthy Kids Program* *Effective 01/01/2018*