ATTACHMENT D: HEALTH CARE OVERSIGHT AND COORDINATION PLAN

Georgia Health Care Plan for Children in Foster Care
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INTRODUCTION

Georgia recognizes that all children require a wide variety of services to promote their ongoing well-being and safety needs. In support of this goal, and in collaboration with its partners, DFCS continues to refine its statewide health care oversight and coordination plan and provide technical assistance to local DFCS offices on the identification and delivery of services to address the physical and behavioral health of children in foster care, including sexual/reproductive health, mental and maternal health. Due to the extraordinary experiences of children who enter care, most will have one or more needs that require immediate attention and sometimes, ongoing care and treatment. As a result, during the intake process of children entering foster care, comprehensive assessments of each child are conducted. Based on these assessments, DFCS identifies the services necessary to ensure continued well-being as well as services to meet any other identified need a child may require.

DFCS embraces the concept of a trauma-informed child welfare practice. Implementing a trauma-informed practice ensures that purposeful attention is placed on the complex traumatic stress experiences of children, including maltreatment and removal from their homes, and that this information is considered in all areas of case planning, placement, treatment and permanency. The impact of acute, chronic, or complex trauma on not only the child, but other members of the family as well as the ongoing emotional health of the family are important to implementing sound trauma informed practice as well.

Based on lessons learned from the implementation of the prior Health Care Oversight and Coordination Plan, included in the 2009-2014 Child and Family Services Plan, the following updates have been incorporated in this new 2015-2019 Health Care Oversight and Coordination Plan:

1. The Department of Human Services (DHS) hired a Medical Director to provide oversight and consultation regarding the medical and psychological needs of children in foster care;

2. In September of 2013, DFCS established the System of Care (SOC) unit, with a team of staff who possess clinical as well as child welfare experience, focused on comprehensive physical, cognitive and behavioral health assessments and service delivery;

3. DFCS has used information from its collaboration with the Administrative Office of the Courts on the Foster Care Cold Case Project and child welfare community partners to examine the use of psychotropic medications and other health concerns of youth in care;

4. The Comprehensive Child and Family Assessment (CCFA) now includes a trauma assessment as a part of the mental health component and training will be developed for
staff on it which will reflect richer trauma informed practice content;

5. DFCS developed a Georgia specific version of the Child Welfare Trauma Training Toolkit (NCTSN). The following has been accomplished since the development of the toolkit:

- The toolkit has been administered to DFCS Permanency Case Managers, Supervisors and Administrators across the state;
  - Training was facilitated by DFCS Education and Training (Professional Excellence Trainers) and DFCS Permanency Expediters (currently Well-Being Specialists);
  - Conducted 42 training sessions between January –November 2010;
- Participation and Georgia representation in national ACF meeting regarding trauma and psychotropic medication use in foster children as part of a team consisting of the Department of Community Health (DCH), Department of Behavioral Health and Developmental Disabilities (DBHDD) and the DHS Medical Director.

6. Georgia Families 360°, the state’s new managed care program for approximately 27,000 children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system, launched on March 3, 2014. Amerigroup Community Care of Georgia, one of the state’s Care Management Organizations (CMO), will provide health care coverage for these populations. Amerigroup will also coordinate the health components of the Comprehensive Child and Family Assessments. Medically fragile children that receive healthcare services through Medicaid waivers are not included in the CMO. DFCS has created a review team to monitor the status of these children and ensure solid transition strategies for their ongoing needs as they leave case;

7. DFCS is collaborating with the Methodist Children’s Home and Chris Kids to develop a Trauma-Informed Systems protocol for the Room, Board and Watchful Oversight (RBWO) placement providers

- Methodist Children’s Home has been awarded a grant through the Substance Abuse and Mental Health Services Administration (SAMHSA), which will be used to train all staff on the Sanctuary model.
- Chris Kids performs the Adverse Childhood Experience (ACE) study on all youth who are placed in their Child Caring Institutions (CCIs). Based on the results, specific trauma-informed treatment is immediately provided;
8. The Georgia Program on Adolescent Traumatic Stress PATS (a community based learning collaborative to build capacity to deliver Evidence Supported Treatments (ESTs) to youth) was established.

- **Target Population** – Adolescents involved in child welfare and/or juvenile justice, especially focusing on youth that are minority and/or lesbian, gay, bi-sexual, transgender or queer/questioning (LGBTQ).

- **Participants:**
  State and Regional Leadership from DFCS, Department of Behavioral Health and Developmental Disabilities (DBHDD), Department of Juvenile Justice (DJJ), Department of Community Health (DCH) as well as CEOs of the chosen providers; DJJ clinical staff and clinical supervisor and 4 clinicians from the following agencies: CHRIS Kids, CETPA, Inc., Child and Teenage Foundation and Pathways Transitional Program.

For the development of the new 2015-2019 Health Care Oversight and Coordination Plan, DFCS has collaborated with partner agencies, health care experts, including pediatricians, and child welfare experts for assistance with evaluating the state’s health care services for children in foster care and to receive recommendations for improvements. Participating collaborators include the Department of Human Services’ Medical Director, representatives from Children’s Healthcare of Atlanta, Satcher Health Leadership Institute at Morehouse School of Medicine, DCH (Medicaid), Department of Public Health (DPH) (Babies Can’t Wait and Maternal and Child Health), Governor’s Office for Children and Families (GOCF), foster parents, former foster care youth, Multi-Agency Alliance for Children (MAAC), EmpowerMEnt, Teen Parent Connection, CHRIS Kids, DBHDD, Georgia Partnership for TeleHealth, CFSP Advisory Committee, CAPTA Citizen Review Panels, Administrative Office of the Courts, Barton Law Clinic and Juvenile Court Judges.

DFCS selected the participating collaborators based on the representative’s subject matter expertise and involvement in health care services. Representatives were contacted by DFCS at various stages of the development process of this plan to review and provide feedback regarding DFCS’ current health care services as well as offer any recommended changes. Feedback was provided in the form of surveys, questionnaires and other qualitative activities administered at meetings and conferences with the collaborators.

Georgia has established a microenterprise process whereby quarterly meetings are held between DFCS, DPH, DJJ and DBHDD to review shared populations of customers and identify barriers to services for those customers. Based on the outcomes of these meetings, strategic plans are developed to address identified barriers or concerns. Examples of meeting outcomes include
establishing regional protocols to ensure children receive the appropriate level of crisis intervention, addressing continuity of services across regional lines, utilizing Local Inter-agency Planning Teams (LIPTs) to develop a central plan of care, identifying shared clients, reviewing cost expenditure assessments and analyzing services for adults. In addition to the interagency collaborations, DFCS regularly consults with and involves physicians or other appropriate medical or non-medical professionals to assess the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

COMPREHENSIVE ASSESSMENT OF NEEDS

DFCS has a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs. All children in out-of-home placements (after the 72-hour hearing) are referred for a formal Comprehensive Child and Family Assessment. As of March 2014, Amerigroup is responsible for coordinating the health components of the CCFA (developmental, dental, vision, hearing, medical and mental health assessments) for all youth enrolled in the Georgia Families 360 program. Within 24 hours of a child entering care, the DFCS case manager initiates the CCFA process by disseminating an electronic notification form (E-Form) to Amerigroup. This initiates the assessment process as Amerigroup assigns the child to a Care Coordination team (CCT), identifies a primary care physician (PCP), primary care dentist (PCD) and mental health clinician or developmental specialist, coordinates the scheduling of health care provider appointments with the identified child, and completes and provides the assessment report to the approved CCFA provider, within the child’s first 25 days of dependency. For youth who are not eligible for enrollment in the Georgia Families 360 program, the DFCS System of Care, Well-Being Specialist, will assist the DFCS case manager in coordinating the initial screening and assessment services. The DFCS case manager will be responsible for submitting any screening or assessment results to the DFCS approved CCFA provider. Neither the child nor the family may have received an assessment in the previous 12 months (DFCS Policy Manual, Foster Care Services, Section 1011.1). If the child or family has received an assessment in the previous 12 months, DFCS case managers must request that an addendum be added to reflect any changes in circumstance that warrant another assessment.

Based on the preliminary information obtained at the time of the child’s entry into foster care, the DFCS case manager determines whether all or some of the assessment components need to be completed on a particular child. The physical, developmental, dental, vision and hearing screens are included as part of the Georgia Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The DFCS case manager must arrange for the child to have an EPSDT visit within 10 days of the child’s placement in foster care. The approved CCFA provider must include the EPSDT screening results as part of the comprehensive assessment report, once it is received from the Amerigroup care coordinator. A Comprehensive Child and
Family Assessment provides the best opportunity to thoroughly evaluate the child and family. Assessments include all available medical and behavioral health, trauma-specific and educational and family information. Additionally, all children ages 4-18 must have a comprehensive trauma assessment as part of their CCFA. The Every Child Every Month visit supports and is an anchor to the continuity of care for children after assessments occur.

Medical Evaluation

An initial medical evaluation is completed for each child entering foster care. Georgia’s plan for initial and follow-up health screenings meets reasonable standards of medical practice. Georgia’s Medicaid EPSDT program currently follows the American Academy of Pediatrics (AAP) 2008 Bright Futures Periodicity Schedule and the schedule’s components are to be completed at each periodic visit. These components include age-appropriate developmental, vision, hearing and dental screens (Refer to the Resources Section of this Plan for the Medicaid EPSDT program information).

For the initial medical appointment, the child is accompanied by the DFCS case manager, caregiver, or DFCS contracted provider, unless contraindicated by safety or child well-being. The child’s medical historian (e.g. parent or DFCS case manager) shall complete a thorough medical history, prior to the child’s initial appointment. Following the appointment, results of all screenings and assessments are provided to the DFCS approved CCFA provider. The DFCS approved CCFA provider will submit the health assessments as part of the complete CCFA to the assigned DFCS case manager. DFCS maintains electronic health files for all children in foster care. Medical information will be updated and appropriately shared by DFCS case managers. DFCS case managers will document all appointments and assessment results on the child’s person detail and health log in the Georgia SHINES, the Statewide Automated Child Welfare Information System (SACWIS). By December of 2014, DFCS case managers will also have access to the Georgia Health Information Network (GHIN), which will provide additional health related information regarding children who enter into foster care. This information will be available through the SHINES system and will specifically provide information on immunizations psychotropic medication and health care appointments. At the Family Team Meeting, Multidisciplinary Team Meeting, case planning, or other parent/caregiver meetings/visits, the DFCS case manager discusses the child’s health history and current needs. Additionally, the DFCS case manager must (a) secure a release of information from the parent to obtain copies of all available health care records, (b) follow county department procedures for obtaining a certified birth certificate for the child, and (c) arrange for the child to have an EPSDT visit within 10 days of the child’s placement in foster care. The Education and Training Services Unit will continue to follow developments in the team strategies so as to connect practical experience lessons learned into the curriculum for team meetings and case planning.

Once initial screenings and assessments are completed, subsequent EPSDT visits follow the
Bright Futures Periodicity Schedule. The health needs identified through the comprehensive EPSDT screenings are monitored and coordinated for treatment services by the Amerigroup CCT for all youth enrolled in the Georgia Families 360 program. Teen parents in foster care are afforded the same opportunity to participate in service delivery for their children to ensure their children’s needs are being met.

**Dental, Vision, Hearing and Developmental Screenings**

An inspection of the mouth is a component of a select number of EPSDT visits. By the age of 12 months, a child should be referred to a dental home and the dental provider should follow the American Academy of Pediatric Dentistry’s recommendations for pediatric oral health care. Routine dental care begins at age three and the Amerigroup CCT works with the DFCS case manager and placement provider/caregiver to schedule a dental screen each year. However, if indicated, a dental referral may be made at any age. If the dental screening yields any concerns or the need for dental treatment, DFCS is responsible for follow-up within 30 days of the EPSDT visit with an approved Medicaid dental provider. For orthodontic services not covered by Medicaid, the DFCS case manager, in consultation with DFCS county leadership and the DFCS System of Care Unit, may submit a waiver request for unusual medical and dental to the social services director (DFCS Policy Manual, Foster Care Services, Section 1016).

If the vision screening yields any concerns, DFCS is responsible for obtaining an ophthalmological assessment and treatment or prescribed corrective devices initiated within 30 days of the screening. If the hearing screening yields any concerns, DFCS is responsible for obtaining an audio-logical assessment and treatment or prescribed corrective devices initiated within 30 days of the screening. If the developmental screening completed as part of the EPSDT visit yields any developmental delays or concerns, a developmental assessment must be completed. The EPSDT provider is responsible for making a referral for the identified assessment(s) and DFCS is responsible for ensuring the child has the identified assessment(s) within 30 days of the visit.

Children enrolled in the Georgia Families 360 program through Amerigroup will have a dental home with a primary care dentist and a medical home with a primary care physician. The Amerigroup CCT will work with DFCS case managers, caregivers, and the System of Care Unit’s Well-Being Specialist’s to assess and monitor ongoing and specialty dental needs of children/youth. For those youth who are not enrolled in the Georgia Families 360 program or other health coverage, the SOC Well-Being Specialist’s will collaborate with DFCS case managers and placement providers/caregivers to assess and monitor ongoing and specialty dental and medical needs.

Children age three and under who are exposed to substantiated maltreatment are referred to Children First for a developmental screening as required by the Child Abuse Prevention and
Treatment Act (CAPTA). Based on the county in which the child resides, the DFCS case manager completes a Children First (DPH) referral form in SHINES and emails or faxes it to the Children First district coordinator. Children First screens all referred children within 45 days of receiving the referral. If developmental concerns are identified, children are then referred to the Babies Can’t Wait (BCW) program for additional assessments and determination of eligibility for services. Children not meeting the criteria for services who have identified concerns are referred to other community resources. Additionally, children age three and over are referred to the Department of Education (DOE) for screening and determination of eligibility for services if developmental concerns are suspected.

As of March 2014, DFCS case managers will be responsible for informing Amerigroup of all Children First/BCW referrals through an E-Form. Amerigroup will be responsible for ensuring that referred children are assessed and that any recommended services are provided. Concurrently, as of March 2014, if dental/vision/hearing/developmental screening results yield concerns, it will be the primary responsibility of the Amerigroup CCT to address those concerns and work with DFCS case managers and SOC Well-Being Specialists, and placement provider/caregiver to schedule any follow-up needed. For services not covered by Medicaid, it will be the responsibility of the DFCS staff to follow-up accordingly.

DFCS case managers, in consultation with supervisors and family members (as well as the child, if age-appropriate), are encouraged to seek a second opinion if it is in the best interest of the child. Medicaid incorporates provisions for obtaining second opinions by other medical or behavioral health providers. As of March 2014, DFCS case management staff will consult with the Amerigroup CCT regarding requests for second opinions.

**Comprehensive Trauma Assessment**

Children ages 4-18 who are placed in the state’s custody are referred for a comprehensive trauma assessment after the completion of the medical evaluation and after the results of the hearing and vision screening have been received. The comprehensive trauma assessment identifies all forms of traumatic events experienced directly or witnessed by the child to determine the best type of treatment for that specific child. In addition to the trauma history, trauma-specific evidence-based clinical tools assist in identifying the types and severity of symptoms the child is experiencing. The comprehensive trauma assessment must provide recommendations and actions to be taken by DFCS to coordinate services and meet the child’s needs.

The CCFA now includes a trauma assessment, which must include:

- A trauma history with information regarding any trauma that the child may have experienced or been exposed to as well as how they have coped with that trauma in the past and present;
• A standardized trauma screening tool; and
• A summary of assessment results and recommendations for treatment (if needed).

Examples of evidenced-based, trauma-specific clinical tools include:
• University of California, Los Angeles (UCLA) Post-traumatic stress disorder (PTSD) Index for the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)
• Trauma Symptom Checklist for Children (TSCC)
• Trauma Symptom Checklist for Young Children (TSCYC)
• Child Sexual Behavior Inventory

Based on individual levels of resilience, not all children who have experienced trauma need trauma-specific interventions. Natural supports should be used when at all possible to assist the child in coping with traumatic experiences. In some cases, children and adolescents may need additional assessments. Other necessary assessments may include psychological evaluations, psychiatric evaluations, psychosexual evaluations, neuropsychological evaluations, substance abuse assessments, or psycho-educational evaluations.

Through partnerships with DCH, DBHDD, DJJ, Amerigroup and the health care provider community, DFCS ensures that every child and adolescent in care receives a comprehensive trauma assessment. Trauma can affect many aspects of a child’s life and may lead to secondary problems that negatively impact safety, permanency and well-being (peer relationships, problems in school or health related problems). These secondary problems often lead to changes in the family system and a family’s ability to meet the needs of their children. Traumatized children and their families touch many service systems. Cross-system collaboration is necessary in order to develop common protocols and exchange of information and interventions.

**Child Traumatic Stress**

Child traumatic stress is the culmination of the physical and emotional responses that a child experiences as a result of direct or indirect threats of harm, safety, or death. These responses tend to overwhelm the child and his or her ability to function in their environment. A child’s psychological and physical safety can be threatened based on these physical and emotional responses in ways that may be more intense than the trauma. Factors impacting traumatic stress include:

• The child’s age and development;
• The child’s perception of the danger faced;
• Whether the child was the victim or a witness;
• The child’s relationship to the victim or perpetrator;
• The child’s past experience with trauma;
• The adversities the child faces in the aftermath of the trauma; and
• The presence and availability of adults who can offer help and protection.

Children in the child welfare system typically face many other sources of ongoing stress that can challenge child welfare workers’ ability to intervene:

• Poverty;
• Racism and other forms of discrimination;
• Separation and frequent moves;
• School problems;
• Grief or loss; or
• Refugee or immigrant experiences.

**Psychological Evaluation**

Based on the comprehensive assessment or any behavioral or cognitive concerns identified by the DFCS case manager, placement provider, teachers, Amerigroup, Well-Being Specialist, or other caregivers, a child may be referred for a psychological evaluation at any point during his or her time in care. The psychological evaluation should address behavioral or cognitive concerns. The psychological report must provide detailed recommendations and actions to be taken by Amerigroup and DFCS in order to coordinate services and meet the child’s needs. Georgia Families 360 will have all mental health assessments and treatment coordinated through Amerigroup. DFCS case managers and Well-Being Specialist’s, placement providers, or behavioral health providers will collaborate with the Amerigroup CCT in order to determine if a psychological evaluation is warranted. The Amerigroup CCT will assist with choosing the psychologist and scheduling appointments for the child.

The psychological evaluation should include, but is not limited to, a review of the following domains or areas:

1. Identifying data
2. Reason for referral
3. Background

4. Past evaluations and treatment

5. Behavior observations/mental status

6. Evaluation results

7. DSM IV-Multi-Axial Diagnosis

8. Summary and recommendations including:
   a. The referral question and presenting problems;
   b. Validity statement (e.g. this evaluation appears to be a valid reflection of this child's level of functioning.) For children with identified special needs, incorporate if the provider feels like the test results are valid based on the abilities of the child;
   c. Placement recommendations (if appropriate);
   d. Treatment recommendations;
   e. Referrals for additional assessment (if necessary);
   f. Signature of Licensed Psychologist and date.

It is the responsibility of the Psychologist to review previous psychological reports to determine if an intelligence quotient (IQ) test needs to be repeated within the three-year window. If an IQ test does not need to be repeated, it is expected that the psychologist will use the extra time for extended achievement screening or personality measures. An IQ test must be repeated:

- If a child was under seven years of age at the time of the earlier IQ test;
- If the child has had a head injury or evidence of serious mental illness has emerged since the initial evaluation; or
- If the child’s medication status has changed (was not on medication for earlier evaluation and is currently on medication or the reverse).

If a child has identified special needs, the validity of any test results must be interpreted in terms of those special needs.

Children or adolescents may require additional specialized assessments. Examples of specialized assessments include:

- Adaptive Functioning Assessment
• Attachment Disorder
• Dissociative Disorders
• Learning Disability
• Neuropsychological
• Occupational Therapy Evaluation
• Psychiatric Evaluation
• Psychosexual evaluation
• Specialized Medical
• Speech and Language Evaluation
• Substance abuse
• Trauma Assessment (sexual, physical)

**Specialized Assessment: Substance Abuse and Mental Health**

DBHDD has partnered with DFCS to provide inpatient and outpatient substance abuse and mental health treatment services for youth in care. Inpatient services for substance abuse are provided through the substance abuse clubhouses. The clubhouses provide outpatient substance abuse treatment as well as three (3) inpatient substance abuse treatment facilities. One facility is dedicated to males only. Through the collaboration with DBHDD and Amerigroup, specific substance abuse services are provided for youth enrolled in Georgia Families 360 through CORE providers. CORE providers are mental health providers within the DBHDD network and are able to provide outpatient individual counseling for substance abuse treatment. CORE providers and other clinicians are also able to conduct substance abuse assessments to determine the type of treatment needed. Youth receive mental health assessments within 18 days of entering foster care and periodically as required. Mental health treatment is dependent on the recommendations of the mental health assessments or identified issues from the caregiver, case manager, well-being specialists, or Amerigroup CCT.

**Psychological and Mental Health Needs**

All children entering foster care have experienced difficult and/or traumatic conditions in their own homes or in previous placements. Caregivers will likely require the assistance of mental health providers in assessing and treating children regarding trauma experienced by the child, which may involve:
• Emotional or behavioral problems evidenced in the foster home or other placement provider, the school or the community;
• Degree of attachment to the birth parent or the foster parent;
• Learning problems/disabilities and/or the appropriateness of school placement;
• Readiness for moving into an adoptive placement or other permanent placement setting;
• The placement resource who is best able to meet the child’s needs; and
• The need for intermediate or intensive residential treatment.

When a psychological evaluation is recommended or required, the DFCS case manager is responsible for collaborating with the Amerigroup CCT or DFCS SOC Well-Being Specialist to assist in arranging an appointment for the child to receive services and giving the provider sufficient background information on the child and the family. Once the evaluation is completed, the DFCS case manager must obtain and file any written information on the child’s diagnosis and treatment in the case record and discuss treatment recommendations with the parent, foster parent or other placement provider and develop plans for implementation, if applicable. The case plan and the case record should reflect agency monitoring of any mental health referral and of the child’s progress in responding to the services provided.

An assessment by means of Psychological, Psychiatric and Speech Therapy Services (formerly known as “PPST”) may be utilized when Medicaid is not available. The following are eligible to receive assessment and treatment services:

• Children in foster care;
• Birth parents of children in care when the permanency plan is reunification or when another permanency plan may need to be selected; and
• Foster parents serving special needs children who require consultation about a specific child in the home.

**Medically Fragile Children and Youth**

Many medically fragile children are under the care of medical specialists. Therefore, they may or may not have received an EPSDT screening. Special services, equipment needs, medical supplies, etc., may be recommended by the physician or EPSDT provider as medically necessary due to the child’s medical condition or diagnosis. The DFCS case manager must collaborate with the Amerigroup CCT, SOC Well-Being Specialists and placement provider/caregiver to arrange and use available resources so that the child in care receives the medical
services/equipment needed.

**HIV Antibody Testing**

If a child has signs or symptoms that may be consistent with human immunodeficiency virus (HIV) or has a health history that places the child at-risk for HIV, the child must be evaluated by a physician to determine if testing is necessary and appropriate. Minors may receive HIV prevention counseling and testing services with or without parental consent. Whenever possible, parents should be involved in the counseling and testing (DFCS Policy Manual, Foster Care Services, Section 1011.3).

Almost all children who have become infected with HIV are infected prenatally by their mother. The maternal HIV antibody is present in children up to 18 months of age, resulting in a *false positive*. A *true negative* finding can only be made 18-24 months following birth.

Primary health care providers should be able to care for HIV-exposed children and for most asymptomatic HIV-infected children with normal immune systems. As children become symptomatic, they will need the care of a pediatric infectious disease specialist. The Amerigroup CCT will collaborate with the DFCS case manager and placement provider/caregiver to locate knowledgeable HIV specialists for consultation and information. Since the child with a depressed immune system is at greater risk of suffering severe complications from routine childhood illnesses, such as chicken pox and measles, the physician needs to be consulted about the degree of restricted setting that is best for the child. Usually, the benefits of an unrestricted setting outweigh the risks of the child acquiring harmful infections. More often than not, the infected child can be served in a foster home and attend school and/or day care.

The results of HIV testing are confidential and may be released only to the following individuals: parents (unless child is in the permanent custody of DFCS and then, a case by case decision is made), child’s custodian, foster parent (or other provider), Amerigroup CCT, and any health care provider who has a legitimate need to know such information.

**Sexual Health Needs**

The sexual and reproductive needs of youth in foster care are addressed through the initial and follow-up EPSTD health screening. Children and youth with sexual/ reproductive health risks identified through either a routine EPSTD health screening or the comprehensive trauma assessment receive targeted interventions. Additionally, youth in foster care receive health education and risk prevention services through Georgia's Personal Responsibility Education Program (PREP). PREP serves the larger goals of DFCS by providing high risk youth (ages 10-19) in Georgia free access to evidence-based teen pregnancy prevention programs and supplemental adult preparation subjects. PREP educates youth on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including...
HIV/AIDS. In addition to sex-education programming, PREP provides education on five adulthood preparation subjects to youth in foster care (healthy relationships, healthy life skills, adolescent development, career preparation, and financial literacy). Youth in foster care access PREP services through the agency’s partnership with the Department of Public Health’s Adolescent Health and Youth Development (AHYD Program). PREP is federally funded by ACF and the Family and Youth Service Bureau (FYSB).

During federal fiscal year 2013, 1,486 youth were served through PREP. Baseline data for these youth indicate that prior to participating in PREP, 47% of surveyed PREP participants report having had sexual intercourse, 44% of surveyed PREP participants report intention to have sexual intercourse in the next year, 48% had not received information on birth control, 47% had not received pregnancy testing, and 48% had not received STD testing or treatment. The data provides further evidence of the need to ensure youth have access to medically accurate evidence-based sexual health information. Additionally, data on youth completing PREP suggest the program has been effective in reducing risky sexual behavior among youth. At exit, 40% of youth participants report they are more likely to abstain from sexual intercourse in the next year, 62% of participants report being more likely to use or ask a partner to use some method of birth control and 68% of participants report being more likely to use or ask a partner to use a condom.

One of the identified gaps between programs and services is that many participating youth report challenges accessing teen friendly sexual/reproductive health services. To mitigate this challenge, PREP has been instrumental in linking youth to clinical services within their communities.

**MEDICAID AND SERVICE ELIGIBILITY**

The Department of Community Health has selected a single, accountable managed care organization (Amerigroup) to coordinate the healthcare needs for all children youth and young adults in custody. In doing so, all members will have access to a full spectrum of proactive healthcare monitoring and interventions, some of which were previously not available or tracked in any coordinated way.

The majority of children transitioned to state custody are eligible for Medicaid and participation in the Medicaid EPSDT program and other medically necessary and appropriate physical and behavioral health services. (Refer to the Resources Section of this Plan for information on transitioning of Medicaid services for children entering foster care)

The EPSDT program is available for Medicaid-eligible recipients up to the age of 21. This eligibility span includes children who turned 18 while in state custody and are eligible for Medicaid’s Chafee Foster Care Independence Program. These and other benefits continue through the day prior to the youth’s 21st birthday. In addition, based on Health Care Reform,
those youth who age out of foster care at 21 will be eligible for continued Medicaid services until the age of 26.

When a youth in foster care is not eligible for Medicaid or Title IV-E funding, the care standards presented in this Health Care Oversight and Coordination Plan apply regardless of payment mechanism (Medicaid, IV-E, IV-B, state, county or third party).

All immigrant children can be provided foster care services without regard to their immigration status. However, compliance with federal funding restrictions and other legal requirements makes it essential to determine the immigration status of all children in care. The DFCS case manager must request an interpreter to assist with language interpretation when English is not the primary spoken language of the child, parents, or relatives. The Limited English Proficient and Sensory Impaired (LEP/SI) request is accessed through the County Department’s Client Language Services Coordinator (DFCS Policy Manual, Foster Care Services, Section 1011.21).

CONTINUITY OF HEALTH CARE SERVICES

Georgia is committed to ensuring the continuity of health care services, including establishing a medical home for every child in care. A medical home is a partnership between the patient, the family and the primary care physician in cooperation and coordination with specialists and community resources. The primary care physician is known to the child and family and develops a relationship based on mutual responsibility and trust. The DFCS case manager works in collaboration with the Amerigroup CCT and parent/caregiver to establish a primary provider home for each child that will provide diagnostic, preventive, restorative, and emergency care throughout childhood. The designated primary care provider will make referrals to other specialist based on identified dental, vision and hearing needs of the child. Children enrolled in the Georgia Families 360 Medicaid program will have a medical and dental home.

One of the primary goals of DFCS is to maintain children within their home community and to attempt to ensure that siblings are placed within the same home. By making diligent efforts to maintain children in their home communities, children will be able to maintain their connections to school, friends, religious and other community organizations, and health care. As a key component of concurrent planning, the agency is developing partnership parents who work with birth parents toward reunification or other permanency for the child. Partnership parents are committed to assisting children and their birth families in maintaining continuity of health care, including the selection of or continuation with primary health care providers.

The DFCS case manager is primarily responsible for ensuring appropriate and timely medical care for a child in care and for obtaining health-related documents for the case record (DFCS Policy Manual, Foster Care Services, Section 1011.2). The Amerigroup CCT will assist and support children, DFCS case managers and placement providers/caregivers with arranging appropriate and timely medical care for children in care enrolled in the Georgia Families 360 Medicaid program.
program. When a youth in care is not eligible for enrollment in Georgia Families 360 or other Medicaid program, the DFCS SOC Well-Being Specialists will assist DFCS case managers with the coordination of health-related services.

The Amerigroup CCT is the hub of Amerigroup's work and ultimately the success of the CCT model will be the barometer of success in serving this population. The CCT will perform multiple functions that will facilitate, if not directly address, the medical needs of children in care.

Each child will have a customized team assembled to be responsive to his or her specific needs. Composed of clinical and specialized care coordinators, the majority of which are trained mental health clinicians, the CCT is charged with ensuring the child’s care plan is followed. Based on DFCS policy and EPSDT standards of medical practice, the CCT staff members also serve as liaisons between the DFCS case manager and the providers in the Amerigroup network, who are responsible for performing the initial and ongoing medical assessments. The CCT will assist with making appointments and will be responsible for coordinating scheduling with DFCS case managers and placement providers.

- The CCT approach is to collaborate with DFCS case managers to understand the individual needs of each foster care youth they support and to enhance the ability of the DFCS case managers to attend to the well-being needs of each youth. The CCT will accomplish this by not only supporting the DFCS case manager in medical coordination, but also by the addition of a layer of monitoring of health care status and promotion of integrated health coordination.

A Health Risk Assessment (HRA) will be administered to each youth upon entry into DFCS custody and updated annually or as indicated. The HRA will supplement the findings from the initial medical assessments performed by Amerigroup’s providers by evaluating risk factors and discovering elements of healthcare needs not easily ascertained through claims and other data analyses. The HRA is completed by an individual who best knows the child.

- Results of the HRA collected by Amerigroup ensure that the CCT is the first to be aware of previously unidentified needs and as a result can proactively plan for needed supports and services.

A health care plan will also be developed for all youth in care and housed in the SHINES case record. The health care plan is the individualized service/treatment plan developed by the CCT to uniquely address the needs of each youth.

- The CCT is responsible for tracking implementation of the health care plan and for resulting improvements (or lack thereof) in health status and functioning. The CCT is charged with the responsibility for updating the health care plan based on failure of the child to achieve expected outcomes, including redirecting to a new provider, working with an existing provider to develop new health care pathways or identifying new
interventions, or seeking new approaches to service delivery to which the child might be more responsive.

- Based on the needs identified in assessments and health care plan goals, the responsive provider resources are assembled. If indicated, in no later than 30 days following the initial assessments, a behavioral health provider is identified. For those children with the most intensive need, the CCT will participate in periodic Family Team Meetings held by DFCS.

When the youth is initially placed, the DFCS case manager obtains as much information as possible about the child’s health history prior to or at the time of initial placement. If possible, the DFCS case manager asks the parent to discuss the child’s medical needs and provides that information to the Amerigroup CCT through the designated E-Form. All health information collected is shared with the foster parent or placement providers and medical providers.

Amerigroup’s provider network must provide sufficient access to primary and specialty care.

- Each youth will have a primary care physician and a primary care dentist as part of their medical and dental home.
- The CCT, as a result of information collected from the DFCS case manager, placement provider/caregiver and medical, dental and mental health assessments will be able to match identified needs to available resources early in the placement process.
- The CCT will work with the DFCS case manager to determine the providers who are able to render services in the child's placement area.

As the CCT is aware of a child's needs through initial contacts with DFCS case managers, by completing health care plans and health risk screenings, they can work with DFCS case managers and placement providers/caregivers to refer to appropriate providers in the community.

**Transition Planning**

DFCS has established policies and practice to ensure continuity of services for all children exiting foster care into permanent homes and for youth exiting to emancipation. A Family Team Meeting (FTM) must be held whenever there is a critical case juncture, which includes a child exiting foster care (DFCS Policy Manual, Foster Care Services Section, 1007). Additionally, a Written Transitional Living Plan (WTLP) must be completed for every youth age 14 years and older and a Transition Roundtable (TRT) must be held within 90 days, prior to a youth exiting foster care to emancipation (DFCS Policy Manual, Foster Care Services Section, 1012.3). Therefore, prior to their planned exit from foster care, all youth must have a FTM and/or a TRT. The exit FTM or TRT is used as a forum for sharing the youth’s health care needs (physical, vision, dental, hearing, mental, behavioral and sexual) with the youth, permanent caregiver and/or support team. The youth exiting foster care and the permanent caregiver must participate.
in an exit FTM and/or a TRT. At the FTM and/or TRT, DFCS shares, at a minimum, the following:

a. Child medical history, including vision, dental, immunization, sexual;

b. Child behavioral health history, including trauma and substance use;

c. Contact information for medical and behavioral health providers;

d. Discussion of any medications (purpose, dosage, frequency, side effects, prescribing doctor and repercussions to the child if the medicine is discontinued without physician oversight);

e. Paper copies of SHINES health details/logs for the child;

f. Paper copies of SHINES medical files of minor children;

g. Medicaid card, birth certificate, social security card; and

h. Dates of pending appointments, EPSDT assessments/screenings.

Amerigroup will continue to monitor and serve the health needs of youth 18-26 years of age, regardless of their foster care status. Youth will have access to their health information through Amerigroup as well as the Georgia Health Information Network. Additionally, Amerigroup will assist DFCS case managers, caregivers and transitioning youth by informing them of the healthcare options (health insurance, health care power of attorney, health care proxy, etc.) for youth upon reaching the age of 18. Youth that are eligible for CHAFEE Medicaid are eligible for Former Foster Care Medicaid under Amerigroup. Former Foster Care Medicaid provides coverage up to age 26 for youth over the age of 18 who were in DFCS custody during the month of their 18th birthday. To be eligible, youth must have been enrolled in foster care during the month of their 18th birthday and have a social security number. There is not an income limit and this includes physical as well as behavioral health needs. Amerigroup will also coordinate with the Department of Behavioral Health and Developmental Disabilities regarding collaboration of health and developmental needs for any youth receiving a Developmental Disabilities Medicaid Waiver. DFCS will emphasize the importance of children in care and exiting care with knowledge of their health status and equipped to respond to and manage chronic conditions.

OVERSIGHT OF PRESCRIPTION AND PSYCHOTROPIC MEDICATIONS

DFCS policy requires that placement resource providers develop a plan to monitor access and use of medications. To restructure and streamline the process of oversight of prescription medicines and use of psychotropic medicines, DFCS established the following guidelines:

1. All medications (non-prescription or prescription) must be given by the resource
provider. Children/youth may not self-administer medications.

2. Non-prescription medications: No child shall be given a non-prescription medication, unless the child exhibits symptoms that the medication is designed to relieve.

3. Prescription medications, including psychotropic medications:
   a. Prescription medications shall only be given to a child as ordered by the child's medical provider and as directed on the child’s prescription.
   b. Medications prescribed for one child may not be given to any other child.
   c. A child's attending physician, DFCS case manager and parent shall be notified in cases of dosage errors, drug reactions, or if the prescription medication does not appear to be effective.

4. Resource providers shall maintain a record of all medications handed-out by the resource provider or other adult and taken by children to include: name of child taking medication, name of prescribing physician and date of prescription (if the medication is prescription or psychotropic), required dosage, date and time taken, dosage taken, and name, signature and title of the resource provider/adult that handed-out and supervised the taking of the medication.

5. All prescription and non-prescription medications shall be kept in a locked storage cabinet or container, which is not accessible to the children and stored separate from cleaning chemicals and supplies or poisons. The keys to the locked cabinets or containers shall not be accessible to children.

6. All expired medications shall be discarded and not handed out for use.

7. If placement changes, all medications shall be delivered to the adult caregiver responsible for administering the medication. Medication shall not be given to children to transport to the new placement.

The DHS Medical Director, in partnership with the DFCS System of Care staff, the Department of Behavioral Health and Developmental Disabilities and the Department of Community Health, has developed and implemented a statewide behavioral health oversight and monitoring protocol. This protocol includes:

1. Comprehensive and coordinated behavioral health screening, assessment and treatment planning for youth identified as having behavioral health and trauma-related needs. This includes psychiatric evaluation and treatment through psycho-pharmacology;

2. A uniform psychotropic medication informed consent process, to include decision-
making by youth, caregivers and other key stakeholders; and


The first step of this process has been completed in the development and implementation of the Consent and Review Guidelines. These guidelines include a standardized consent form to be used for all children and adolescents in foster care and specific timeframes for consent responses (Refer to ATTACHMENT D-1 of this Plan for the Guidelines for Psychotropic Medication in Children and Adolescents).

In efforts to better coordinate medical care and to ensure consistency and appropriateness of provider practices for the more than 8,000 children in foster care on any given day, a multi-step approach has been taken. In 2012, the DHS Medical Director initiated an evaluation process surveying 30, then interviewing 19, foster care children (age 0-5) with the highest needs across Georgia.

On September 24, 2012, a single Medicaid data extract was delivered to DFCS from DCH, representing every child in DFCS custody with a Medicaid identification number. This data on 7,377 foster care children was analyzed to assess the psychotropic medication use across Georgia for foster care children. The results demonstrated that 26.7% of 7,377 children in custody had at least one psychotropic prescription active on September 24, 2012. Whereas, 17.3% of the foster children population had either two or three prescriptions or 4.0% were using four or more psychotropic medications.

In terms of child placement, children in DFCS family foster homes and children living with relatives had relatively low rates of prescription usage, 13% of 2,293 children and 7.6% of 971 children, respectively. Higher usage was observed in Child Placing Agencies (CPA) foster homes with 38.7% of 1,799 children and Child Care Institutions (CCI) with 60.9% of 1,004 children.

Gender analyses revealed that males have higher prescription rates, 29.9%, than females, 23.71%. Likewise, older children consumed more psychotropic medications than younger ones. About 3.1% of children under five years of age used psychotropic medications (usually to control seizures). 30.1% of children (five to nine years of age) had active psychotropic medication prescriptions, compared to 47.4% of children over 10 years of age with active psychotropic medication prescriptions.

Antipsychotic medications were used by 9.62% of the foster care population. Children under 10 years of age used antipsychotic medications infrequently at 2.0%, compared to children 10 years of age and above, at 21.78%.

The most common class of psychotropic medication used was stimulants, followed by antidepressants/anti-anxiety medications, antipsychotics, adrenergics (for ADHD), and
anticonvulsants. Less frequently seen were anticholinergics, benzodiazepines, non-stimulant, ADHD medications, and sedatives/hypnotics.

The Medical Director initiated a tracking process utilizing a collaborative approach across divisions. DFCS, with the cooperation of DCH, has established a process to transfer Medicaid treatment and prescription data for foster children into a specialized database. This database allows DFCS to identify trends and treatment used for select subsets of cases or individual cases. This is a huge step towards implementing a sustainable system to track the medication, diagnosis, prescribing, and utilization patterns of children and youth in foster care.

The following are the measures already implemented by DFCS:

1. **Proactive Measures**:
   - Training: DFCS staff, case managers and providers were provided live webinars on the use of psychotropic medications. The plan is to continue webinar trainings on these related topics for our staff, providers as well as stakeholders;
   - Standardized Informed Consent Process (Refer to ATTACHMENT D-1 of this Plan for the Guidelines for Psychotropic Medication in Children and Adolescents);
   - DFCS case managers are able to address any concerns regarding psychotropic medication regimens with the Well-Being Specialists of the System of Care Unit. The Well-Being Specialists staff the case with case managers, meet with prescribing physician regarding agreed upon concerns and develop alternative plans with placement provider, DFCS case manager, Amerigroup CCT and prescribing physician to make recognized adjustments to youth’s medication. If an agreement cannot be established, the case is escalated to the DHS Medical Director and Amerigroup Medical Director for doctor to doctor review.

2. **Diagnostic Review of Children reflective of population with High Psychotropic Medication Use**:
   - In step 1, an intensive process was undertaken to identify children under 5 years of age, using psychotropic medication, whose cases should be reviewed;
   - In step 2, determination of the extent and appropriateness of psychotropic medication usage in these children was done. This was followed up by review of Medicaid data for all foster children (all age groups).

3. **Information Review Using Data from DCH (Medicaid) as a collaborative effort with DFCS**:
• Implemented a process to define information needed to understand the demographics and extent of psychotropic medication use in foster care;
• Initiated technology measures to receive data from DCH;
• Amerigroup has also developed a Psychotropic Medication Management plan for youth in the Georgia Families 360 program which includes:
  o A 100% medication review of every child in care on one or more psychotropic medication;
  o Ensuring that evidence-based medication protocols are followed;
  o Ensuring that all medications are appropriate for identified diagnoses;
  o Identifying clinical outliers and trends among Georgia prescribing physicians for children in foster care; and
  o Education and consultation for prescribing physicians, foster parents, placement providers, and DFCS case managers.

Seeking opportunities to strengthen and leverage the collaboration with the medical and education communities to broadly address needs and outcomes for children will continue to be a priority.

2015-2019 Health Care Oversight and Coordination Goals

Recognizing the high-risk nature of the foster care population, DFCS is taking additional steps to ensure that children and youth in foster care receive optimal health care and oversight. As such, over the next five years, DFCS will:

1. Fully implement the Child Welfare Trauma Systems Readiness Tool. The Trauma Readiness tool will be administered to front line Social Services case managers in all program areas in order to assess:
   o The agency’s understanding of the impact of traumatic stress on children it serves;
   o The agency’s understanding of parent/adult trauma history and its impact on parenting and parent’s responses to services;
   o Trauma and the Child Welfare System;
   o Vicarious Trauma of Child Welfare Professionals; and
   o System Integration and Collaboration with other Child-Serving Agencies.

2. Provide training for all Social Services staff in trauma screening

3. Develop protocol for ongoing trauma screening for all children/youth in care, including choice of an evidenced-based screening tool
4. Increase trauma training for child welfare staff, foster care parents, mental health providers, and other community partners

5. Integrate a screening tool designed to assess a child’s trauma history into child welfare practice

6. Increase cross-system collaboration

7. Build community capacity of trauma treatment providers for children and adults

8. Provide increased staff support to decrease staff turnover, secondary trauma and increase stability and support for families

9. Fully implement the Georgia Health Information Network Link through the SHINES system in order to give case management staff access to health information through the DCH Virtual Health Record network. DFCS case managers will have nearly real time access to doctor visit records and changes in the medical treatment of children in their charge. Currently, there is a lag between when a doctor visit occurs or treatment changes are prescribed and when the DFCS case manager is informed. During this time, the DFCS case manager must arrange for contact with the health care provider and obtain the record of the visit and arrange for contact with the provider, if there are questions. Taking advantage of the newly developed statewide Health Information Network (HIN) and technology available through Amerigroup, DFCS case managers will be able to access their children’s health records online and view changes or updates as soon as they occur.

10. Provide training and education assistance to DFCS case managers and physicians to improve their understanding of best practices around psychotropic medication use. Foster care youth of appropriate age will also receive educational materials about psychotropic medications, including “A Guide on Psychotropic Medications for Youth in Foster Care”, soon to be published by Emory University’s Barton Clinic in collaboration with DFCS.

11. Research and identify non-pharmacological interventions to be integrated in DFCS child welfare practice as part of the comprehensive treatment for foster care children, along with pharmacological treatment. In order to utilize any identified non-pharmacological interventions, the DHS Medical Director, along with collaborative partners, will conduct education seminars for physicians to incorporate non-pharmacological interventions as
part of their Best Practices.

12. Continue to work with Amerigroup and DCH to provide training and education around any identified non-pharmacological interventions, build resources for psycho-social treatments (as non-pharmacological interventions) and further improve access to treatments.

13. Finalize the development of and implement the Trauma-Informed Systems protocol for the Room, Board and Watchful Oversight (RBWO) placement providers.

14. Develop and implement activities to support the delivery of evidence supported treatments to youth (Georgia PATS).

15. Ensure that Amerigroup, as part of the health care oversight it provides, will review Psychiatric and Psychotropic medication history of all foster children through a two phase process. In Phase 1, Amerigroup will use a screening tool to get this information on a monthly basis. Providers will be educated on the need for appropriateness of psychotropic medication use as a part of this phase. Additionally, Amerigroup will provide education and training to physicians, therapists, providers (Child Caring Institutions, CSP, Psychiatric Residential Treatment Facilities) to improve their knowledge about psychotropic medications and management of their side effects. In phase 2, changes in prescribing patterns of physicians will be reviewed and addressed by Amerigroup with physicians, as needed.

16. Ensure DFCS case managers, foster caregivers (foster parents and direct care workers in group homes) and diagnosed youth receive on-going education and support to understand specific health needs of youth (maintaining healthy blood glucose levels, healthy weight control and asthma control).
RESOURCES

Division of Family and Children Services (DFCS)

- Approved comprehensive child and family assessment providers:
  - [http://dfcs.dhr.georgia.gov/fostercare](http://dfcs.dhr.georgia.gov/fostercare)
- The Department of Human Services online directives information system, ODIS, houses DFCS policy manuals, including assessment, foster care and adoption services policies, which may be accessed at:
  - [http://www.odis.dhr.state.ga.us/](http://www.odis.dhr.state.ga.us/)
- The DFCS online benefits application for all financial supports:
  - [https://compass.ga.gov/selfservice/](https://compass.ga.gov/selfservice/)
- Guidelines for Psychotropic Medication Use in Children and Adolescents:
  - ATTACHMENT D-1

Department of Behavioral Health and Developmental Disabilities (DBHDD)


Department of Community Health (DCH)

Medicaid EPSDT Services and other Medicaid Services; DCH provides information on Medicaid services available to children in state custody, which can be accessed via the following site:

[https://dch.georgia.gov/medicaid](https://dch.georgia.gov/medicaid)

The EPSDT services manual outlines categories of EPSDT providers and the screening services available under Medicaid’s EPSDT program. Additional diagnostic and treatment services available for Medicaid-eligible children in state custody are identified in other relevant DCH program manuals, such as Medicaid-eligible family planning and dental services. Medicaid dental professionals may be located by calling 1-800-432-4357.
Department of Public Health (DPH)

- Maternal and child health, Children and BCW may be found at:
  - http://health.state.ga.us/

Governor’s Office for Children and Families (GOCF)

- GREAT START GEORGIA, sponsored by GOCF, provides Georgia with an opportunity for collaboration and partnership at the state and community level that will improve health and development outcomes for the most at-risk children and families. The overall goal of GREAT START GEORGIA is to promote maternal, infant and early childhood health, safety and development and strong parent-child relationships by implementing evidence-based home visiting as a major strategy within a comprehensive, community-based early childhood system framework.
  - http://children.georgia.gov/about-us

Georgia Head Start

- Georgia’s Head Start program is compliant with federal guidelines on health screenings and school readiness. Developmental, vision, hearing and dental screenings within 45 days of enrollment in Head Start are required by federal law.

Children’s Healthcare of Atlanta (CHOA)

- http://www.choa.org/

Brain and Spinal Injury Trust Fund Commission

- www.bsitf.state.ga.us

Social Security Administration

- http://www.ssa.gov/
ATTACHMENT D-1

GUIDELINES FOR PSYCHOTROPIC MEDICATION USE IN CHILDREN AND ADOLESCENTS

DIVISION OF FAMILY AND CHILDREN SERVICES
Purpose

Improvement in the practice and procedure of informed consent in regards to all psychotropic medication for children and adolescents in foster care. In addition, promote positive clinical outcomes through increased understanding, compliance and empowerment of staff, caregivers, and recipients.

Introduction

The Administration for Children and Families (ACF) requires that all children in foster care who are receiving psychotropic medication are monitored in a manner that ensures their continued safety and well-being. Ongoing research has shown that there are a disproportionate number of children in foster care who are prescribed psychotropic medication as compared to the general population of children.

The Georgia Division of Family and Children Services (DFCS) strives to ensure children’s safety, permanency and well-being, whether with families of origin or in out of home placements. Safety is insured by the promotion of increased parental capacity of families to maintain children within their own homes and communities when diagnosed with psychiatric illness.

The need for psychotropic medication for children and adolescents should be based on a thorough assessment of need as determined by a physical, psychological and psychiatric evaluation. Ideally, any psychotropic medications deemed necessary are prescribed by a psychiatrist who has received specialty training in the treatment of children and adolescents with psychiatric illness; however other medical professionals or physician extenders may also serve as prescribing physicians (pediatrician, nurse practitioner, and physician assistant). Informed consent is to be obtained prior to youth taking any new psychotropic medication. Informed consent is not necessary for each change in dosage or for discontinuation of any psychotropic medication. Non-pharmacological interventions are to be considered in conjunction with and in some instances prior to initiating psychotropic medication therapy. It is important that Division staff, caregivers and community partners serving children in care understand the psychiatric disorder, available treatment options, possible side effects, and expectations of treatment.

This set of guidelines is a statement of policy and best practice for the treatment of children in out of home care with psychiatric illness, who may require psychopharmacologic therapy as a part of their treatment. It outlines the DFCS’:

- General principles for psychotropic medication
- Principles for informed consent
- Principles governing medication safety
**General principles regarding the use of psychotropic medication in children and adolescents in foster care:**

- Prior to any prescription of psychotropic medication, a current DSM-IV diagnosis must be made by a licensed, psychiatrist/physician/physician extender.

- Except in the case of emergency (e.g. suicidal ideation, severe psychosis, self-injurious behavior, physical aggression that is dangerous to self or others, or severe impulsivity that endangers self or others) informed consent must be obtained prior to beginning psychotropic medication.

- All caregivers (biological parent/guardian, relatives, foster parents, and residential staff) of children in the custody of DFCS must be informed of the requirement for informed consent prior to filling any prescription or administration of psychotropic medication.

**Principles for Informed Consent**

*Informed Consent refers to agreement to undergo or obtain treatment after being informed of and having an understanding of risks and benefits involved.*

- Informed consent shall be obtained from the County Director/or Designee for each psychotropic medication prescribed.

- Informed consent forms should include at a minimum the child/adolescent’s diagnosis, target symptoms, risks and benefits of pharmacological treatment, common side effects and rare or severe potential adverse events, alternatives to proposed medication, prognosis, necessary laboratory studies (blood work) and potential medication interactions.

- DFCS will provide to each placement provider/caregiver a Medication packet to be used, which will include:
  - DFCS Psychotropic Medication Consent Form
  - A pre-filled FAX cover page with the contact name and number for designated person/s of consent.
  - DFCS Medication log form

- The assigned case manager will ensure that placement providers and caregivers are aware of and agree to notify the responsible Department office within two (2) business days after receiving a new psychotropic medication prescription.

- Informed consent forms with approval or denial of consent will be returned to the prescribing physician within 72 hours of receipt unless additional questions or concerns arise.
• If written informed consent prior to starting psychotropic medication is not possible, verbal consent may be obtained from the DFCS County Director or designee. An informed consent form should be received by the DFCS County Director (or designee) and provided to prescribing physician within 72 hours of prescription in these cases.

• Children/Youth, parents and caregivers should be included in the discussion of new prescriptions for psychotropic medication on an ongoing basis. Notification of new psychotropic medications should be provided to parents or guardians with whom the Department received custody or reunification is the goal, within 72 hours of consent. Case management staff can achieve this by letter or face to face contact.

• Informed consent forms should be renewed every year to include signatures even if no changes have occurred in the psychotropic medication treatment plan. This is to be reviewed and noted at each case plan review period.

**Principles governing medication safety**

The Food and Drug Administration (FDA) indicates that there are no limitations placed on the ways in which a physician may prescribe an approved medication. Keeping this in mind, when the use of psychotropic medication is necessary:

• Preference is given to beginning with medications that have been FDA approved for that child’s age group and diagnosis.

• Medication that has shown efficacy for a given age group and diagnosis are preferred over newly approved medications by the FDA.

• Treatment with a single medication for a single symptom or disorder should be tried before treatment with multiple medications is considered.

• Supporting documentation is required for the use of two (2) or more medications for the same symptom or disorder.

• All medications should be initiated at a low dose and increased gradually in order to observe effects.

• DFCS Case Managers must discuss prescribed psychotropic medication with children/adolescents and caregivers during monthly face-to-face contacts. This discussion should include target symptoms as well as possible side effects of psychotropic medications.

• DFCS Case Managers in conjunction with caregivers should contact prescribing physicians in regard to side effects, deterioration in condition or lack of improvement and discuss next steps in psychotropic medication treatment planning.
• DFCS Case Managers should review medication logs and obtain copies at least monthly during Every Child Every Month visitation to be filed in child/adolescent’s SHINES record.

Please note

**There are some placement providers that utilize an alternative medication log format (MAR), which can be accepted in the place of the DFCS Medication Log form.**

**State agencies like DJJ have a designated consent form for youth in Youth Detention Centers (YDC) and Regional Youth Detention Centers (RYDC), which is an acceptable form for consent of those youth.**

**This consent process impacts all psychotropic medications prescribed on or after May 1, 2013 only.**