**Children in Foster Care Are a High Cost Medicaid Population**

- Represent 3.2% of children in Medicaid but 15% of children using behavioral health care
- Have the highest penetration rate for use of behavioral health services of any aid category of children (32% of children in foster care use behavioral health services compared to 26% of children on Supplemental Security Income, and 4.9% Temporary Assistance for Needy Families)
- Have the highest mean behavioral health expenditures of any aid category of children ($8,094 per child compared to $7,264 for children on SSI)
- Have overall Medicaid mean expenditures (physical and behavioral health care) of $12,130 per child – costs are driven by behavioral health care
- Children in foster care who use behavioral health services have costs that are 7× higher than for Medicaid children in general

**Children in Foster Care Use More Restrictive, More Expensive Services in Medicaid**

- More likely to use:
  - Inpatient psychiatric services
  - Residential treatment and therapeutic group care
  - Emergency room services
  - Psychotropic medications
- Children in foster care are only 1/5 the size of the TANF population but use nearly the same amount of dollars for residential and group care and ER visits and 3.5 times more for psychotropic medications

**Children in Foster Care Have High Rates of Psychotropic Medication Use**

- Children in foster care are 3.2% of Medicaid child population, but nearly 13% of Medicaid children using psychotropic medications
- 23% of children in foster care use psychotropic medications paid for by Medicaid (compared to 27% of children on SSI and 4% of TANF children)
- Are more likely to receive 2 or more concurrent psychotropic medications than other aid categories of children (49% FC, 46% SSI, 26% TANF) – also 3, 4, or 5 or more
- Of children getting anti-psychotics, 42% are in foster care (42% are on SSI, 18% are TANF)
- Have highest mean expenditures for psychotropic medications of any aid category of children ($934 FC, $916 SSI, $475 TANF)
What Especially Drives Medicaid Costs (and often poor outcomes) for Children in Foster Care?

- Use of emergency room for regular care
  - Strategy: Medical home, WI

- Use of emergency room for asthma-related issues

- Inappropriate Use of Psychotropic Medications
  - Strategies: Red flag monitoring (too young, too many, too much) and consultation/education of prescribers as in OR and WI; Psychiatric consultation to primary care docs as in MA (Massachusetts Child Psychiatry Access Project); Informed consent supported by access to psychiatric consultation as in IL and VT

What Especially Drives Medicaid Costs (and often poor outcomes) for Children in Foster Care?

- Duplication of Services (e.g., multiple assessments, multiple care coordination)
  - Strategies: common screening/assessment tools; fidelity Wraparound approach with dedicated care coordinator, low ratios (1:10)

- Longer lengths of stay and multiple placements in foster care associated with higher Medicaid costs
  - Strategies: fidelity Wraparound, Family Finding, Strengthening Families, others

Lessons from States: Customization for Children in Foster Care in Medicaid

Medicaid service delivery and payment models need to reflect attention to state child welfare, Medicaid, and behavioral health system policies and goals –

- Collaborative planning, design, implementation needed
- Explore potential for Medicaid match from child welfare – most children are Medicaid eligible; many services paid for by child welfare are Medicaid-allowable (NJ, AZ, MI)
- State agencies need to approach implementation in partnership with managed care entities

Integration at the Systems/Medicaid Purchaser Level: Caveats

Research has shown that...

- When adult and child behavioral health dollars are integrated, there is a risk of child behavioral health dollars being absorbed by adult services
- When physical and behavioral health dollars are integrated, there is a risk of behavioral health dollars being absorbed by physical health services

Especially in the absence of customization within the design for children with serious BH challenges, risk-adjustment strategies, strong contractual performance measures, and monitoring mechanisms.

A word about a “special benefit” for foster care population through a foster care carve out...

- TANF and SSI-enrolled children need the same service array as foster care population (while prevalence rate for behavioral health is higher for children in foster care than TANF population, there are many more TANF children)
- Children don’t stay in foster care forever (median length of stay in 2011 was 13.2 mos.) but tend to remain Medicaid-eligible and in need of services
- Can lead to unintended consequences of parents having to relinquish custody to access care (especially an issue for children with serious behavioral health challenges)
Customization Strategies – Regardless of System Design
Trauma-Informed Screening and Early Intervention
(7/27/13 CMCS and SAMHSA Informational Bulletin and 7/11/13 SNB Letter)

- Mandate use of standardized screening tools and inclusion of behavioral and developmental (not only physical health) screens (MA)
- Incorporate state child welfare requirements for physical, behavioral and dental health screens within specified timeframes
  - A2: Urgent response requiring behavioral health screen within 72 hrs of entering care and “fast track” linkage to services
  - MA: Medical screening required within 7 days and comprehensive exam within 30 days, including behavioral health/use of standardized tools
- Require inter-periodic screens when child enters foster care, or changes placement, or tied to length of stay in foster care
- Quality payments for providers meeting trauma-informed standards
- May require enhanced rate (MA)

Customization Strategies – Psychotropic Medications
(7/23/13 and 11/23/13 SNB Informational Bulletin and 11/22/11 State Medicaid Directors
Tri-Agency Letter on Appropriate Use of Psychotropic Medications Among Children in Foster Care)

- Track and monitor outlier use, e.g., too young, too many, too much (growing number of states like WY, MD) – interface with Drug Utilization Review Board
- Provide consultation to prescribers, including primary care providers (MA, VT)
- Orient MCOs to state’s informed consent and assent policies in child welfare
- Provide coverage and training for treatment alternatives
  - (aggression, sleep disorders)

Customization Strategies – Values-Based, Goal-Oriented Utilization Management Criteria

- Access: require no prior authorization for basic behavioral health outpatient services up to certain limit (MA)
- Coordinated Care: require that plans of care developed through Wraparound process determine medical necessity (with outlier management) (AZ, MA, NI, LA)
- Require no “fail first” criteria to access services or medications – move away from “levels of care” to strengths-based, standardized assessments (e.g., CANS) (NI, MA)
- Prior auth for certain psychotropic meds, e.g., antipsychotics for young children (MD)

Customization Strategies – Service Coverage
(May 7, 2013 CMCS and SAMHSA Informational Bulletin)

- Cover a broad array of behavioral health home and community-based services
  - MA: In-home services; family peer support; mobile response; therapeutic mentoring; behavior management therapy and monitoring; intensive care coordination using a Wraparound approach
  - AZ: Mobile response and stabilization; therapeutic group home care; treatment homes/therapeutic foster care; intensive care management; Wraparound process; behavioral assistance; intensive in-home/community services; transportation; youth support and development
- Cover a range of crisis options, including a newer generation model of mobile response and stabilization and telebehavioral health capacity (WI, NJ, MA)
- Cover evidence-based practices, e.g. Trauma-Focused Cognitive Behavioral Therapy , Multisystemic Therapy, Functional Family Therapy, Multidimensional Treatment Foster Care (growing number of states)

Customization Strategies – Provider Network

- Include providers knowledgeable about the child welfare population
  - AZ: sexual abuse, trauma
  - MA: state required same network of providers across all MCOs for behavioral health home and community-based services (Rule 50)
  - requirements for expertise in trauma-informed care
  - TN: Best Practices Network
- Develop protocols and practice guidelines related to children in foster care and interface with child welfare system
  - AZ: how to work with the child welfare agency and the courts; clinical needs of the child welfare population
- Broaden the Medicaid provider network and include: providers trained in co-occurring mental health and substance use; EBPs; trauma informed care; racially/ethnically diverse providers; inclusion of families/youth with lived experience as providers; knowledgeable about child welfare system (NJ, MA, AZ)
- Enhance rates for providers trained in EBPs and trauma-informed care

Customization Strategies – Orientation and Training

- Incorporate orientation/training for MCOs and providers on children with significant behavioral health challenges, foster care population, child welfare system, role of court (MA)
- Incorporate training for Medicaid providers on effective practices
  - Wraparound approach (MA, MI, NJ, LA, MD)
  - Trauma-Focused CBT and Parent Management Training-Oregon Model (MI)
  - Trauma-informed care (AZ, MA)
  - Screening tools (MA)
  - Managing and Adapting Practice (MAP) (CA)
Customization Strategies – Data and Performance Requirements

- Specific tracking and reporting of:
  - Child behavioral health penetration rates and utilization (services and medications) stratified by age, gender, race/ethnicity, aid category, region, diagnosis, service type, medication type.

- Performance expectations (not only HEDIS)
  - A2: PH-access to primary care, adolescent well care visits, annual dental visits, immunization measures; BH-emotional regulation, avoiding delinquency, stability of living situation, substance abuse, children in psychiatric hospitals awaiting placements
  - B6: BH-reduced use of residential treatment, maintenance in the community, improved functioning using Child/Adolescent Functional Assessment Scale (CAFAS)
  - NJ: PH- timeliness of assessments and comprehensive exams; exams in compliance with EPSDT guidelines; semi-annual dental checks; immunization measures; BH-access to BH services following EPSDT assessment; clinical and functional outcomes using Child/Adolescent Needs and Strengths (CANS)


Analysis

- Significant behavioral health conditions

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Customization Strategies – Administrative and Financing

- Risk-adjust rates for children in child welfare and children with serious behavioral health challenges (A2)
- Utilize population case rates for high utilizing child populations (W, I, I)
- Incorporate special lien on MCOs for child welfare-involved children, children enrolled in Wraparound, youth transitioning, and hold periodic meetings with child welfare and MCOs for trouble shooting and quality improvement
- Incorporate a quality review process that involves families and youth with lived experience on quality review teams and requires input from other child systems (e.g. child welfare).
- Hire/contract with family organizations to serve as family advocate; requirements for MCOs to involve families and youth in staff and advisory capacities.
- Require reinvestment back into child home and community services.
- Capacity to train, coach and develop the capacity of providers, administrators, staff, families/youth to implement desired reforms.

Customization Strategies – Customized Intensive Care Coordination

- Incorporate intensive care coordination using Wraparound approach for children with serious behavioral health challenges (growing number of states – MA, LA, NJ, IA; PRTF Waiver Demo; CHIPRA Care Management Entity Quality Collaborative states)
  - Intensive care coordination rates for this population range from $780 pmpm to $1,300 pmpm (CHCS Matrix)
  - Inability intensive care coordination/Wraparound approaches, all-inclusive cost of care (e.g. admin, care coord, placements, clinical treatment, informal supports) averages $3,700-$4,200 pmpm (about $2,100 is Medicaid) – compare to $9,000 pmpm in PRTFS, higher in psych inpatient
  - Require that every child has a designated primary care provider - e.g., medical home - and coordination between physical and behavioral health care providers

Customized Care Coordination Approaches for Children with Serious Behavioral Health Challenges

- Care Management Entities
  - Organizations providing intensive care coordination at low ratios (1:10) using high quality Wraparound approach
- High Quality Wraparound Teams
  - providing intensive care coordination at low ratios embedded in supportive organization, such as CMHC, FQHC or school-based mental health center

Analysis of Medical Home Services for Children with Significant Behavioral Health Conditions

“All behavioral health conditions except ADHD associated with difficulties accessing specialty care through medical home”

“The data suggest that the reason why services received by children and youth with behavioral health conditions are not consistent with the medical home model has more to do with difficulty in accessing specialty care than with accessing quality primary care.”

- Need for more intensive care coordination approaches for children with significant behavioral health conditions

“Strengthening, [2010 Feb-Mar 31 (2) 92-9].”

Customization Strategies – Other Administrative Supports

- “Warm line” for child welfare workers and caregivers
  - It is also very helpful to have child health units or designated staff in child welfare to interface with MCOs; Medicaid administrative case management and Title IV-E can both be used to help finance this capacity (NJ, UT)


Analysis

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Wraparound with fidelity is increasingly considered “evidence based”

- State of Oregon Inventory of EBPs
- California Clearinghouse for Effective Child Welfare Practices
- Washington Institute for Public Policy: “Full fidelity wraparound” is a research-based practice

CMS/SAMHSA Joint Informational Bulletin

Issued jointly by the Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration in May 2013

Purpose to assist states to design a benefit that will meet the needs of children, youth, and young adults with significant mental health conditions


Importance of Informational Bulletin

For State Medicaid Agencies
For State and Local Child Welfare Agencies
For Youth and Young Adults
For Family Advocacy Efforts

CMS/SAMHSA
Joint Informational Bulletin

New Jersey—Rehab Option and Targeted Case Management

Department of Children and Families Division of Children’s System of Care (CSOC)

Contracted Systems Administrator: PerformCare – ASO for child BH carve out

Provider Network
Mobile Response & Stabilization Services
Mobile Home Health Services

*Use CANS
*Medicaid and DCF-certified providers

Benefit Design

Intensive Care Coordination: Wraparound Approach
Parent/Youth Peer Support Services
Respite
Mobile Crisis Response and Stabilization
Intensive In-Home Services
Funds

Trauma Informed Systems and Evidence-Based Treatments
Addressing Trauma

Landmark Federal Communication

“The Department of Health and Human Services (HHS) has become increasingly concerned about the safe, appropriate, and effective use of psychotropic medications among children in foster care.”

— November 23, 2011
Psychotropic Medication Quality Improvement Collaborative (PMQIC) Center for Health Care Strategies (www.chcs.org)

- Six state teams (IL, NJ, NY, OR, RI, VT)
- Three-year system change initiative
- PMQIC Data Subgroup
- QI project planning and impact measurement
- Technical assistance (TA)
  - Monthly TA calls
  - Monthly TA e-newsletter
  - Bi-monthly webinars
  - SharePoint resource center

Questions/Discussion

Data Definitions and Common Measures in Support of Psychotropic Medication Oversight and Monitoring

Christopher Belloni, MD
Associate Professor, Tufts University
Clinical Consultant, CHCS

Level of Research Support for Psychotropic Use With Children

Antipsychotic Medications

- Use of antipsychotic medications is amongst the fastest growing class of psychiatric medications.
- Use in Medicaid-enrolled Children age 3-18 grew 62% between 2002 and 2007.
- 354,000 children in 2007 were taking a second-generation antipsychotic (SGA).
- Evidence to support this increase for most conditions remains limited.
- Wide range in state utilization from 2-21%.
- ADHD is the most common diagnosis (39%, Bipolar 11%, ADHD and Bipolar 12%).
The Challenge

- Evidence for the effectiveness of pediatric pharmacotherapy remains rather limited
  - Cornish et al. (2011); Melson-Whitte et al. (2008); More & Pories, 2012
- This is especially true for youth with:
  - Complex treatment needs
  - Histories of multiple treatment failure
- These youth present with intense or chronic mental and behavioral health problems
  - Patrick, Warner, & Miner, 2005
- Brain continues to develop through adolescence
- Impact of adding psychoactive medications to a developing brain is unknown
  - Cornish et al., 2006

Psychotropic Medication Philosophy

- Psychotropic medication should be prescribed cautiously and as part of an evidence-based treatment plan.
- Physicians need to:
  - Identify reasons for emotional and behavioral impairment
  - Assess impact of medication on emotion and behavior
  - Evaluate the benefits and risks of current psychotropic regimen
  - Make ongoing decisions about the need for and effectiveness of psychotropic use
- Youth should be on the medications they need to meet their treatment needs and no more (the principle of sufficiency).

Science/Practice Gaps

- Current levels of psychotropic prescribing are not supported by research
  - Briggemann et al., 2008; Mojtabai & Olfson, 2010
- There is a disconnect between research and day-to-day practice needs
  - Gruttadaro & Miller, 2004
- Research studies, algorithms and clinical guidelines typically only apply to using a single psychotropic medication for a single diagnosis (no comorbidity).

Lifelong Effects of Early Childhood Adversity and Toxic Stress

- The potential consequences of toxic stress in early childhood for the pathogenesis of adult disease are considerable.
- Behavioral level-evidence of strong link between early adversity > health threatening behaviors.
- Biological level- growing documentation of extent of cumulative stress over time and timing of specific environmental insults > structural and functional disruptions > physical and mental illness in adults.
  (Shonkoff & Garner, Pediatrics Vol. 129, No. 1, January 2012)

Diagnosis

- Diagnostic and Statistical Manual (DSM) was originally designed as a research instrument.
- Problems with diagnoses lead to faulty treatment strategies, they serve as the foundation upon which treatment decisions are made.
- Children must meet adult criteria for most of the major mental illnesses including Depression, Bipolar Disorder, Anxiety, PTSD and Schizophrenia.
Diagnosis

- Shift to increasingly defining behavior as biologically determined.
- 4000% (40 fold) increase in the diagnosis of Juvenile Bipolar disorder in the last decade.
- Comorbidity being seen as the norm so each symptom becomes a focus of medication intervention.

PMQIC Data Subgroup

- Comprised of representatives from each of the six participating states (IL, NJ, NY, OR, RI, VT)
- Goal: Identify and agree upon common definitions and measures that each state could implement to address the inappropriate use of psychotropic medications.

PMQIC Data Definitions

- Foster youth: children placed away from their parents or guardians in 24-hour substitute care and for whom the state agency has placement and care responsibility (federal definition)
- Young children: all children under age 6 (5 years and 364 days old)
- Consent: defined by individual state laws or regulations (if they exist)

PMQIC Data Definitions cont.

- Psychotropic medications: medications being used for an emotional or behavioral condition
- Medications automatically assumed to be for a psychiatric indication and included in this definition:
  - Antipsychotics
  - Stimulants
  - Antidepressants
  - Benzodiazepines
  - Anti-anxiety medications (incl. Buspar)
  - Mood stabilizers (e.g., Lithium)

PMQIC Data Definitions cont.

- Polypharmacy: children taking more than one psychiatric medication or more than one medication within the same class (e.g., 2+ more antipsychotic medications) or “co-pharmacy”
  - Child would need to be taking the medications simultaneously for 90+ days to be considered poly- or co-pharmacy
Dosage Guidelines

- FDA approval for use in a pediatric population
- Multiple indications in youth
- No FDA indication for the pediatric population
- None of the above sources set forth any guidance

Minimum Metabolic Monitoring Protocol for Second Generations Antipsychotics (SGAs)

- Personal and family history: Baseline and annually
- Waist circumference: Baseline and annually
- Weight and BMI: Baseline, every 4 weeks up to 12 weeks, and then quarterly
- Blood pressure: Baseline, 12 weeks and annually
- Fasting plasma glucose: Baseline, 12 weeks and annually
- Fasting lipid profile: Baseline, 12 weeks and annually

Baseline Measures for Metabolic Monitoring

- Baseline measures for monitoring second generation antipsychotics (SGAs) following the ADA/APA adult consensus guidelines
  - Exception: lipids checked annually, rather than every five years
  - States can set their own protocols requiring more frequent measures, but this list = minimum standard
  - States may monitor other meds – metabolic or other labs (i.e., Valproic acid, Lithium, etc.) – can define themselves

Common Measures

Data gathered at baseline, and over the course of the 3-year initiative, will measure the percentage of children in foster care:

- On any psychotropic medication
- On specific classes of medications (e.g., antidepressants, stimulants, mood stabilizers, antipsychotics)
- On more than 1 medication from the same class (e.g., antipsychotics)
- On 2, 3, and 4+ psychotropic medications
- < 6 years old on any psychotropic medication
- < 6 years old on 2, 3, and 4+ psychotropic medications
- <6 years old on antipsychotics

Will also measure:

- Implementation of evidence-based or promising interventions for sleep disorders and/or aggression
- Development of an informed consent process or increased adherence to the state’s informed consent process
Best Practices

Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children’s mental health and trauma-treatment needs.

Informed and shared decision-making and methods for on-going communication.

Effective medication monitoring at both the client and agency level.

Availability of mental health expertise and consultation regarding both consent and monitoring issues.

Mechanisms for accessing and sharing accurate and up-to-date information and educational materials related to mental health and trauma-related interventions.

Questions/Discussion

Disclosures of Potential Conflicts

Oversight of Psychotropic Medications in Foster Children: The Illinois Model

Michael W. Naylor, M.D.
University of Illinois at Chicago
Director, Clinical Services in Psychopharmacology

DCFS Rule 325

Administration of psychotropic medications to children for whom DCFS is legally responsible.

DCFS Rule 325

- Challenge
  - provide informed consent
  - provide safe and effective care
  - delivered in timely manner
  - protect rights of foster children
  - provide longitudinal oversight
Centralized Psychotropic Medication Consent Program

- Two components
  - Centralized Psychotropic Medication Consent Line
    - DCFS
    - Authorized Agent
  - Clinical Services in Psychopharmacology
    - University of Illinois at Chicago

Centralized Psychotropic Medication Consent Line

- Concept
  - DCFS is the legal guardian for ~15,300 youth
  - The Office of the Guardian is responsible for providing consent for medical and psychiatric treatment

Clinical Services in Psychopharmacology

- Objectives:
  - provide independent review for all psychotropic medication requests
  - monitor utilization of psychotropic medications
  - provide consultation on particularly complicated cases

Clinical Services in Psychopharmacology

- Objectives:
  - notify the Guardian where provider patterns warrant review
  - conduct training for DCFS, foster parents and childcare providers on psychotropic medications
  - disseminate information regarding new pharmaceutical developments and alerts

Consent Process
**Clinical Services in Psychopharmacology**

- Consultant recommendations:
  - approved
  - denied
  - modified
  - reviewed (emergency medications only)

**UIC Consultation Team Recommendations**

![Pie chart showing CSP recommendations]

**Clinical Services in Psychopharmacology**

**Oversight**

- Informal oversight
  - feeds back through the Office of the Guardian or to the CSP program
  - Administrative Case Reviews
  - GAL, Office of the Public Guardian
  - Regional nurse

**Clinical Services in Psychopharmacology**

- Formal oversight
  - case-specific
    - independent medication review
    - watch list – high risk children
    - record review
Clinical Services in Psychopharmacology

- Formal oversight
  - system-wide
    - utilization patterns of psychotropic medications
    - watch list – high risk prescribers
    - emergency medication use

Clinical Services in Psychopharmacology

- Formal oversight
  - system-wide
    - sources of data
      - UIC Clinical Services in Psychopharmacology consent database
      - DHFS pharmacy claims data
      - DCFS Statewide Automated Child Welfare Information System

Clinical Services in Psychopharmacology

- Formal oversight
  - system-wide
    - quarterly reports
      - timeliness
      - error rates
      - medications without consent
      - denials

Clinical Services in Psychopharmacology

- Formal oversight
  - system-wide
    - polypharmacy
    - high-risk preschoolers
    - weekly reports
    - emergency medications

Quality Improvement

- Competition Times (DARTs)

Polypharmacy

- Words on psychotropic medications by age group and sex
Copharmacy

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Emergency Medications

Facility Report

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Outcomes

Rate of Diagnosis of Bipolar Disorder

Impact of Consultation

SGAs and Weight Gain
Impact of the Clinical Services in Psychopharmacology

- The CSP can:
  - assess statewide diagnostic patterns
  - monitor rate of utilization of psychotropic medications
  - identify adverse effects of medications
  - implement evidence-informed consent strategies
  - assess impact of changes in consent strategies on prescriber behaviors

Enhancements Through PMQIC

- Psychotropic Medication Quality Improvement Collaborative (PMQIC)
  - 3-year quality improvement collaborative involving 6 states (IL, NJ, NY, OR, VT and RI) who have convened a cross-agency team to develop and implement new approaches to psychotropic medication use for foster children

Enhancements Through PMQIC

- Improved data sharing between the state child welfare agency and the state Medicaid agency
- Dissemination of a guideline for the use of psychotropic medications for preschool-aged children

Enhancements Through PMQIC

- Design and implementation of a clinic that provides evidence-based evaluations and psychosocial treatments to preschool-aged children to decrease the reliance on psychotropic medications

Enhancements Through PMQIC

- Design and implementation of a protocol to improve the quality of screening for the metabolic syndrome in foster children on second generation antipsychotics

Questions/Discussion
The New Jersey Model: Psychotropic Medication Policy, Oversight and Monitoring

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The New Jersey Model: Psychotropic Medication Policy, Oversight and Monitoring

Child Protection and Permanency (CP&P)

- 10 Area Offices provide direction and support to the 46 Local Offices throughout the state
- Each local office is led by a Local Office Manager
- Each area has a Clinical Consultant who acts as liaison with community providers

Office of Child and Family Health (OCFH)

- Provides expertise, guidance and support to all divisions of DCF and DCF leadership regarding child and family health, mental health, dental care, substance abuse, and working with expert providers
- Supports the field, utilizing specialized knowledge for problem solving in working with Medicaid, aging out youth, and access to services
- Clinical Team
- Child Health Units

Children's System of Care (CSOC)

- Serves children and adolescents with emotional and behavioral health care challenges and their families; and children with developmental and intellectual disabilities and their families.
- Perform Care is the Contracted System Administrator
- Addiction Services
- Care Management Organizations
- Family Support Organizations
- Mobile Response and Stabilization

Well Being: DCF Child Health Values

- Access
- Continuity
- Child/Family Centered
- Quality
- Integration
- Partnership
OCFH - Clinical Resources:
Clinical Team

- Chief Medical Officer – Provides statewide support to the CPP staff in responding to requests for consent/advocacy about medical illnesses, treatment and procedures
- Child and Adolescent Psychiatrists – Provide expertise, guidance and support to DCF leadership re: development, healthy families, child psychiatric diagnosis and treatment; provides consultation to CPP staff re: children and families under supervision;
- Pediatric Neuropsychologist – Provides expert consultation, review of records, observation, and evaluation focusing on children and youth with intellectual disabilities

OCFH – Clinical Resources:
Child Health Units

- Each Child Health Unit has a Clinical Nurse Coordinator, Health Care Case Managers (HCCMs), and Staff Assistants
- HCCMs includes RNs, BSNs, and APNs
- HCCMs provide health care case management for health care needs of all children in out of home placement

Role of the Child Health Unit (CHU)

- Develop a healthcare plan specific to the child’s health needs
- Coordinate healthcare services to ensure access to health care and timely follow-up
- Facilitate effective and frequent communication among:
  - CP&P
  - Child Health Program
  - Resource Families
  - Birth Families
  - Child/Adolescent

Child Health Indicators
for Children in Out-of-Home Placement

Child Mental Health Initiatives

- Mental Health Screening – 3 components
  - EPSDT
  - CHU nurses use the Pediatric Symptom Checklist
  - Casework staff use NJ MHST introduced through full day workshop on Trauma and the Brain and the importance of screening and early recognition of MH need
- Refer for mental health assessment if indicated
- Forensic Guidelines
- Psychotropic Medication Policy

NJ Psychotropic Medication Policy Development

- Reviewed Psychotropic Medication Policies of other states and Professional Guidelines - AACAP, CWLA, AAP
- Developed policy components consistent with DCF values and case practice model
- Convened an internal workgroup
- Convened a Psychotropic Medication Advisory Group
- Issued policy in January 2010; revised May 2011
**NJ Psychotropic Medication Policy**

**Key Component: Treatment Plan**
- Grounded in OCFH values
- Based on diagnosis and developed in collaboration with the child and family
- Specifies baseline strengths and needs
- Target symptoms are stated in everyday language
- Treatment goals stated in measurable terms
- Treatment interventions +/- medications
- Periodic review and reassessment

**Key Component: Psychiatric Evaluation**
- Must include:
  - History (development, education, family, medical and psychiatric history, past current medications, allergies)
  - Physical examination
  - Mental status examination
  - Diagnosis
  - Goals and target symptoms
- Medication, if recommended, must be appropriate to the diagnosis of record and prescribed as part of a treatment strategy with non-pharmacological interventions

**Key Component: Medication Guidelines**
- Medications with FDA approval for age/diagnosis are preferred.
  - If off-label, medications with greater evidence supporting efficacy and safety are preferred;
  - If off-label, or multiple medications, prescriber must document rationale
- Change one medication at a time
- Start low, go slow
- Make periodic attempts to reduce or stop medications
- Appendix: Safety Monitoring Guidelines
- Appendix: Prescribing Parameters

**Key Component: Informed Consent**
- Psychotropic medication is non-routine treatment and requires specific consent
- Biological parents have the right to consent; CP&P Local Office Manager may consent when parents cannot
- Prescriber must provide information about risks, benefits and alternatives to the proposed treatment for this child/youth
- CHU Health Care Case Manager RN for the child may provide consultation
- Child Psychiatrist may be consulted regarding the treatment, whether it is reasonable to consent, and may request further consultation with the prescriber or team members

**Monitoring and Oversight Model**
- On-going: Health Care Case Manager RNs provide on-going monitoring of all medical needs, and utilize a well-being tool to focus on progress
- Up-Front: Informed Consent protocol and consent consultation offers up-front review of the indications, risks and benefits of treatment and alternatives before medication is started
- During treatment: Quarterly reviews provide opportunity to review all children on medication, policy compliance and to review cohorts at risk; supplemented by semi annual chart review of random sample of all children
- At any time: Case Consultation with the full clinical team at any time for any child is available

**Monitoring and Oversight: Ongoing**
- Health Care Case Managers (nurses) provide on-going monitoring of each child’s medical needs
- HCCMs utilize a Well-being Tool for each child/youth in out of home care. Are they progressing? Are they well?
- Chart Reviews – semi-annual random sample of all children in out of home care
Monitoring and Oversight: Up-Front

- In New Jersey the right to provide consent resides with the child/youth's biological parents or the Local Office Manager in loco parentis
- If a question or concern remains after the prescriber has provided the rationale for recommending medication, the local office team may request consultation regarding the recommendation
- Child Psychiatrist reviews the consultation request and additional supporting documentation and may request further consultation with the prescriber or team members.

Monitoring and Oversight: During

- Every quarter the HCM completes a review of all children on caseload on psychotropic medication
- OCFH reviews and compiles the data to assess data regarding children on psychotropic medication in out of home care and in policy compliance:
  - Prescriber discipline
  - Psychotropics with a consent (any & up to-date)
  - Children/youth with a treatment plan (any & up to-date)
  - Children/youth with a psychiatric evaluation (any & up to-date)
  - Children/youth receiving non-pharmacological interventions

Monitoring and Oversight: Anytime

- Case Consultation with the full clinical team at any time for any child
  - May be requested when there is concern re: diagnosis, failure to progress in treatment, medically complex child, others
  - Opportunity for clinical team to provide school observation, attendance at treatment meetings
  - Capacity for team neuropsychologist or child psychiatrist to provide an evaluation

Monitoring and Oversight: During

- Further review of cohorts (children ages 0 – 5 years old on psychotropic medication; children and youth on more than 3 medications) are analyzed for compliance with prescribing parameters, rational treatment, and whether or not follow-up is required
- If indicated, further consultation with the ID team
- Data are analyzed based on set of common measures established through the Center for Health Care Strategies PMQIC

The New Jersey Model

- Policy was developed to reflect the guidelines proposed by professional and advocacy organizations adapted to the needs of New Jersey's children and families to reflect our core values.
- Oversight and monitoring has been elaborated and refined to enable child specific oversight as well as broad monitoring of psychotropic medication utilization
- Internal and external partners (CP&P, CSOC, CHU, Clinical Team, CMOs, providers) are essential to implementation
- Partnership with CHCS, PMQIC states, and other resources have helped refine our procedures and point to new directions to better serve these children and families
Questions/Discussion

Federal Medicaid Guidance

7/11/13 State Medicaid Director’s Tri-Agency Letter on Trauma-Informed Treatment

5/7/13 Informational Bulletin on Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions

3/27/13 Informational Bulletin on Prevention and Early Identification of Mental Health and Substance use Conditions

8/24/12 Informational Bulletin on Resources Strengthening the Management of Psychotropic Medications for Vulnerable Populations

11/21/11 State Medicaid Directors Tri-Agency Letter on Appropriate Use of Psychotropic Medications Among Children in Foster Care

Resources

Faces of Medicaid: Examining Children’s Behavioral Health Service Utilization and Expenditures
http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261588#.U1gmMvldUud

Making Medicaid Work for Children in Child Welfare: Examples from the Field

Customizing Health Homes for Children with Serious Behavioral Health Challenges
http://www.chcs.org/info_url_nocat3961/info_url_nocat_show.htm?doc_id=1261326

Psychotropic Medications Quality Improvement Collaborative:
Improving the Use of Psychotropic Medications Among Children in Foster Care
http://www.chcs.org/info_url_nocat3961/info_url_nocat_show.htm?doc_id=1261326

CHIPRA Care Management Entity Quality Collaborative
http://www.chcs.org/info_url_nocat3961/info_url_nocat_show.htm?doc_id=1261326

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