

## Improving the Use of Psychotropic Medication for Children in Foster Care: State Profiles

Children in foster care, who typically rely on Medicaid to cover their physical and behavioral health service needs, are more likely than other children to receive psychotropic medications.\*

In response, as part of federal legislation passed in 2012,<sup>†</sup> states were newly required to develop protocols for the appropriate use and monitoring of psychotropic medications for children in foster care.

To help states advance this effort, the Center for Health Care Strategies (CHCS) led *Improving the Use of Psychotropic Medication among Children and Youth in Foster Care* — a three-year, multi-state learning and quality improvement collaborative made possible through support from the Annie E. Casey Foundation. The collaborative brought together teams from state Medicaid, child welfare, and behavioral health agencies in six states to develop and implement new approaches to the monitoring and oversight of psychotropic medication among children and adolescents in foster care.



The following profiles share key quality improvement achievements from select states that participated in the learning collaborative — [Illinois](#), [New Jersey](#), [Oregon](#), [Rhode Island](#), and [Vermont](#). The profiles can be used by other states interested in developing effective policies and practices for the appropriate use of psychotropic medications for children in foster care.

### DEFINING OVERSIGHT AND MONITORING

There is no nationally recognized definition of oversight and monitoring of medication. CHCS is using the following definitions in the context of psychotropic medication use in children and youth:

- **Oversight** refers to the administrative processes a system has in place to assess whether prescribing is appropriate, and may be either prospective (e.g., prior authorization) or retrospective. Oversight is conducted by the system authorizing care and/or payment, and focuses on the practices of the individual provider.
- **Monitoring** refers to the process by which a system assesses whether the care delivered to individual children and youth is within acceptable limits, and is necessarily retrospective. This can be accomplished through the regular review of utilization reports generated by Medicaid claims or other tracking systems.



\* U.S. Government Accountability Office. “Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions.” December 2011. Available at: <http://gao.gov/products/GAO-12-201>.

<sup>†</sup> U.S. Department of Health and Human Services Administration on Children, Youth and Families. “Information Memorandum: Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medications for Children in Foster Care.” April 2012. Available at: <https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf>.

## Achievements across Collaborative Participants

This diverse group of states implemented a variety of strategies to achieve specific goals related to the improved oversight and monitoring of psychotropic medication use. Although each state's needs and objectives were unique, at the conclusion of the collaborative, states' efforts resulted in several important improvements in the oversight and monitoring of psychotropic medications across the participating states:

- Three states established new uniform consent processes, while two further strengthened existing processes.
- Five states improved their psychotropic medications monitoring systems through various methods, including: (1) ensuring that treatment plans for children were in place; (2) tracking well-being outcomes; (3) monitoring the use of antipsychotics; and (4) implementing "red flags" that would trigger follow-up.
- Workforce development efforts were prioritized in four states to spread best practice guidelines for those prescribing psychotropic medications, including nurses and social workers.

## Next Steps for the Field

As these and other states continue to improve oversight and monitoring, areas for further development include:

- Continued expansion of non-pharmacological services and supports;
- Better incorporation of quality measures;
- Proactive involvement of managed care organizations;
- Ongoing training for caseworkers and providers; and
- Greater attention to the perspectives of children and their families about the use of psychotropic medications.

With increased attention to delivering higher quality care and better outcomes at both state and federal policy levels, it is critically important to maintain focus on efforts that improve psychotropic medication use among children who are at increased risk of fragmented care and poor outcomes. The efforts of these states demonstrate the impact of such a focus on both policy and practice, and ultimately, on outcomes.

### ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

# Illinois



Illinois' Department of Children and Family Services (DCFS) is responsible for the safety and well-being of more than [16,000](#) children and adolescents in foster care. Within DCFS, the Office of the DCFS Guardian (the Guardian) is responsible for providing consent for all medical and psychiatric treatment services to children in its care. DCFS established the *Centralized Psychotropic Medication Consent Program* in the Office of the Guardian to provide consent for the prescription of psychotropic medications.

## Oversight and Monitoring Processes

The Guardian contracts with the University of Illinois at Chicago (UIC) to provide an independent, clinical review of all consent requests from clinicians to prescribe psychotropic medications for children in its care. Clinicians who want to start a child in foster care on a psychotropic medication must submit a consent request to the DCFS consent unit. All consent requests are given to Clinical Services in Psychopharmacology (CSP) at the UIC to provide an independent review and advise the Department's consent decision.

Illinois' Department of Healthcare and Family Services (HFS), the entity responsible for paying for psychotropic medications, provides a second layer of oversight for appropriate drug use. HFS maintains a preferred drug list (PDL) to promote the appropriate use of psychotropic medication. To be included in the PDL, a medication must be proven to be safe and effective. In instances where multiple medications in the same class meet the safe and effective criterion, the decision for inclusion on the PDL is based on cost-effectiveness. Medications that are not on the PDL — antipsychotics for children under age eight, and ADHD medications for children under age six — must receive prior authorization from HFS in order for the pharmacy claim to be paid. To prevent a clinician from having to go through two approval processes — both DCFS and HFS — the agencies have an agreement that DCFS consent serves as the prior authorization.

## Opportunities for Improvement

Through its participation in the CHCS learning collaborative, Illinois identified two opportunities for improvement:

- The high rate of utilization of psychotropic medications in preschool foster children; and
- A shortage of psychosocial services for children.

## Quality Improvement Achievements

The state achieved the following goals as part of its participation in the learning collaborative:

- **Created an interagency agreement allowing for two-way transfer of psychotropic medication payment, medical, and consent data.** The legal departments within DCFS and HFS collaborated to develop an interagency agreement that allows for cross-department data sharing related to psychotropic medication, non-psychotropic medication, medical procedures, and provider and consent information. In 2017, the state began a process of refining and further formalizing this agreement.
- **Attained up-to-date consent for all foster children on psychotropic medications.** The state employed two strategies to achieve this goal. The first strategy modified HFS' pharmacy payment software to prevent payment for medications that have not been approved by the DCFS Office of the Guardian. The second strategy was a provider notification system to communicate when medications were dispensed without consent. After five prescriptions were dispensed without consent (10 prescriptions for institutions/hospitals), providers received an initial warning, followed by a second warning if consent was not received for dispensed medications using the same criteria. If a third offense takes place, the relevant licensing agencies are notified that the prescribers are routinely prescribing or administering psychotropic medication to foster children without consent.
- **Decreased the rate of inappropriate requests for psychotropic medication in children ages 0-5.** A process was established for sending psychotropic medication prescribing guidelines to providers requesting such medications for a child ages 0-5. A flowchart describing the steps for prescribing these medications to children age five and under is also provided, which reinforces the referral of these children to the Continuity of Care Center and the need to explore non-pharmacologic interventions.
- **Developed guidelines for prescribers treating children who are on second-generation antipsychotics to improve metabolic syndrome screening rates.** A [metabolic monitoring form](#) was developed by CSP and distributed to DCFS prescribers, offering guidance on screening children on second-generation antipsychotic medications for metabolic syndrome.

## New Jersey



New Jersey's Department of Children and Families' (DCF) Child Protection and Permanency (CP&P) (formerly the Division of Youth and Family Services) is responsible for the health and well-being of nearly [7,000](#) children in the state's foster care system. New Jersey considers the prescribing of psychotropic medications to be non-routine medical care, which requires the consent of a biological parent if parental rights have not been terminated. In instances where parental rights have been terminated or the parent/guardian is unavailable, the CP&P local office manager generally approves or denies the prescribing of psychotropic medications.

DCF's Office of Clinical Services (OCS) includes a clinical team comprised of two child and adolescent psychiatrists, a neuropsychologist, and a team of consulting pediatricians. In addition, OCS resources include a network of Child Health Units (CHU) located in CP&P local offices that are responsible for assessing physical and behavioral health needs through medical record reviews and home visitation, monitoring follow-up and response to care, and advocating for the health needs of children who enter out-of-home care.

### Oversight and Monitoring Processes

A CHU nurse case manages every child in its care who is receiving psychotropic medication. The OCS clinical team psychiatrists also provide support and education to child welfare managers, supervisors, and CHU nurses; conducts quality assurance reviews on cohorts of children and youth considered at risk (i.e., children under age 6; youth with co-morbidities; and children prescribed four or more psychotropic medications); and reviews psychotropic medication data for children in out-of-home placement.

DCF developed its [Psychotropic Medication Policy](#), concerning the prescribing, use, and monitoring of psychotropic medication, which was formally adopted in January 2010. The policy addresses psychiatric evaluations, treatment plans, authorized prescribers, informed consent, prescribing parameters, and medication monitoring guidelines. When a child is prescribed a psychotropic medication, the CHU nurse is responsible for ensuring that the policy is being followed and that the child is monitored while receiving the treatment. The OCS psychiatrists provide consultation regarding prescribed medications to the nurses and CP&P staff as requested.

### Opportunities for Improvement

Through its participation in the CHCS learning collaborative, New Jersey identified three opportunities for improvement:

- System-level challenges to improving policy compliance and quality — both regionally and locally;
- An opportunity to build a framework to assess the progress of individual children who are taking psychotropic medications; and
- Determining which children on psychotropic medication in foster care are at the highest risk and how best to review those cases.

### Quality Improvement Achievements

The state achieved the following goals as part of its participation in the learning collaborative:

- **Improved policy compliance in treatment documentation for children on psychotropic medications.** A series of trainings were developed for nurses to increase the presence of required documentation of treatment in child welfare health records.
- **Developed training on a quality assurance tool to assess the progress of individual children who are receiving psychotropic medications.** A quality assurance tool was developed, as well as a training curriculum, for its Health Care Case Managers, enabling the Department to monitor outcomes for these children.
- **Created a process for ongoing quality assurance reviews of at-risk groups of children.** To review the treatment progress of these children, New Jersey began documenting at-risk groups in its Nurse Trackers and having them reviewed by an OCS child and adolescent psychiatrist who would follow-up with the CHU nurses and providers as deemed appropriate.
- **Increased capacity in the state's child welfare case management system (NJ SPIRIT) to capture additional information regarding psychotropic medications, utilization, and policy compliance.** Information technology resources were engaged to assist with the inclusion of additional fields in NJ SPIRIT to track psychiatric evaluations, medications, informed consent, and treatment plans.

## Oregon



Oregon's Department of Human Services (DHS) is the state's child welfare agency and is responsible for more than [7,000](#) children in foster care — including being responsible for the administration of psychotropic medications. Children in foster care in Oregon are enrolled in managed care.

### Oversight and Monitoring Processes

Oregon DHS provides consent for the administration of psychotropic medication through local child welfare supervisors. Foster parents are required to notify the child's caseworker in the event a psychotropic prescription has been given. The caseworker must inform the supervisor who either approves or denies the prescription, and then notifies the birth parents and attorneys. If the birth parents do not agree to the administration of medication that has been approved by the supervisor, a court hearing may be necessary.

The Oregon Health Authority (OHA) — which includes the Division of Medical Assistance Program (Medicaid) and the Addictions and Mental Health Services agencies — is responsible for the administration of the medical and mental health programs utilized by children and youth in foster care. DHS and OHA are connected through shared administrative services and offices, and coordinated state plans. DHS and OHA utilize a Drug Use Review Board in the oversight of psychotropic medications and share encounter data across systems.

### Opportunities for Improvement

Through its participation in the CHCS learning collaborative, Oregon identified three opportunities for improvement:

- Statutory requirements concerning the oversight of psychotropic medication use for children in foster care fall solely on DHS, whose staff do not typically have the clinical knowledge needed to determine appropriate use;
- Oversight of psychotropic medication use for children in foster care by each department does not reflect the redesign of integrated and coordinated health care delivery systems; and
- A lack of clinical and behavioral health expertise to support coordinated care organizations (CCOs) and providers considering psychotropic medication use as part of the treatment plan for a child in foster care.

### Quality Improvement Achievements

The state achieved the following goals as part of its participation in the learning collaborative:

- **Improved the effectiveness of the consent process for psychotropic medications use.** [Tip sheets](#) were developed and distributed to field offices for use with caseworkers, foster parents, and youth. DHS' psychotropic medication consent process was also re-evaluated to determine the effectiveness and efficiency of the process. Additionally, the [Oregon Psychiatric Access Line about Kids \(OPAL-K\)](#) was launched for child psychiatric phone consultation to support primary care providers.
- **Increased collaboration among stakeholders to inform policies that improve the appropriate use of psychotropic medications.** A Psychotropic Medication Stakeholder Advisory Committee was created to define high risk prescribing practices and review common drivers. The committee identified trauma as an experience underlying aggression as the common driver.
- **Identified the safety and effectiveness of psychotropic medication use through the utilization of best practices.** Newly adopted best practice guidelines infused with a trauma lens were created and distributed to providers by OPAL K. A consensus opinion regarding prescribing risk flags was distributed to DHS Caseworkers and Supervisors, as well as providers and CCOs.
- **Developed a Medicaid pharmacy data system to identify prescribing practices that might necessitate further clinical review (prescribing "flags").** Areas of focus included: improving appropriate use of antipsychotic medications, reducing the utilization of psychotropic polypharmacy, and assuring appropriate use of psychotropic medications for children under six years old. CCOs were provided access to pharmacy prescribing flags to support utilization review and quality improvement practices. OPAL-K was contracted to provide clinical consultations with providers when prescribing flags were triggered for youth in foster care.

## Rhode Island



Rhode Island's Department of Children, Youth and Families (DCYF) is the agency responsible for the planning, development, and evaluation of a comprehensive and integrated statewide program of services for children involved in child welfare — including more than [1,800](#) children in foster care.

While Rhode Island's child welfare system is state administered, it has four regional offices that represent Providence, Northern Rhode Island, East Bay, and West Bay/South County. Regional offices ensure the well-being of children through community supports, networks of care, permanency goals, and by supporting families in achieving those and other objectives.

The Department of Human Services (DHS) and Neighborhood Health Plan of Rhode Island (NHP) also play a role in the authorization, oversight, and financing of psychotropic medications for foster children. DHS, the state's Medicaid administrator, contracts with NHP to provide comprehensive, managed, and integrated medical and behavioral health services to children in foster care.

### Oversight and Monitoring Processes

At the start of the *Improving the Appropriate Use of Psychotropic Medication among Children and Youth in Foster Care* learning collaborative, Rhode Island was in the process of developing a policy to guide the utilization of psychotropic medications among children in foster care. Despite DCYF, DHS, and NHP working together to ensure comprehensive medical and behavioral health care for children in foster care, there was little guidance around the appropriate use of psychotropic medications and the state's information systems were not designed to track psychotropic medication use — resulting in a lack of individual- and system-level monitoring.

### Opportunities for Improvement

Through its participation in the CHCS learning collaborative, Rhode Island identified three opportunities for improvement:

- Need for interagency policies/procedures on use as circumstances require or blanket authorization for psychotropic medications;
- Need for more guidance around acceptable prescribing of psychotropic medications; and
- Primary care physicians or psychiatrists differing levels of training and experience in child/youth behavioral health.

### Quality Improvement Achievements

The state achieved the following goals as part of its participation in the learning collaborative:

- **Developed an informed consent process that utilizes medical expertise.** A medical review office was created employing a part-time child and adolescent psychiatrist to conduct prescribing reviews. To educate practitioners on the new process, a psychotropic medication review policy was developed, regional trainings were conducted, and informational materials were mailed to psychiatrists and psychiatric nurse practitioners providing care to children in DCYF custody.
- **Implemented a monitoring system to track psychotropic medication use.** In collaboration with NHP, the state implemented a quarterly child-level data extract — containing psychotropic medications, hospital use, and behavioral health services received through the health plan — which allowed DCYF to track and report on psychotropic medication monitoring and quality of care.
- **Created a response system to ensure appropriate use of psychotropic medication.** A process was created to review cases involving children receiving psychotropic medication, where children are: (1) under age six; (2) receiving more than one medications in the same class; or (3) receiving three or more medications. To ensure parties were aware of their role: (1) training was conducted for regional DCYF directors, administrators, child welfare supervisors, and probation supervisors; (2) monthly medication reviews were held with DCYF directors and the probation administrator; and (3) clinical staff attendance at placement planning meetings was required as appropriate.
- **Instituted evidence-based, trauma-informed assessment practices.** The Child and Adolescent Needs and Strengths Assessment (CANS) was implemented for all youth entering congregate care (e.g., group homes and residential treatment) or specialized foster care. Assessment data is captured by the state's information systems and integrated with data from DCYF and NHP.
- **Implemented evidence-based, trauma-informed treatment options.** The state began exploring the option to create a foster care clinic at Hasbro Children's hospital designed to treat the unique behavioral health needs of children in foster care. Other evidence-based trauma-informed treatment practices are also being phased in, including: Trauma Systems Therapy, Trauma-Focused Cognitive Behavioral Therapy, and Alternatives for Families Cognitive Behavioral Therapy.



## Vermont



Vermont's Department of Children and Families (DCF), Family Services Division (FSD) — within the Agency of Human Services (AHS) — is Vermont's child welfare agency serving more than [1,000](#) children and youth in care at the time of the collaborative. The DCF is responsible for all children in the department's care, while family services social workers are responsible for providing consent to medical recommendations on behalf of the child in custody, including the use of psychotropic medications.

### Oversight and Monitoring Processes

When a child enters DCF custody they are enrolled in Green Mountain Care — the state's Medicaid program — which covers the child's medical needs, including all medications. The Department of Vermont Health Access (DVHA) administers Green Mountain Care. DVHA's pharmacy program covers medications included in the Preferred Drug List (PDL), which are recommended by the Drug Utilization Review (DUR) Board. The PDL includes medications for behavioral health treatment, many of which require prior authorization. In addition to making recommendations for inclusion in the PDL, the DUR Board routinely reviews patterns in the prescription, dispensation, and consumption of medication and offers advice on strategies that may improve patient outcomes and lower costs.

In 2011, the Department of Mental Health, in collaboration with the DVHA, convened a workgroup to review medication prescribing patterns and to identify guidelines for various departments to adopt regarding the prescribing of psychotropic medications for children, including children in foster care. Following the release of the workgroup's findings, AHS charged the workgroup with making specific recommendations to: (1) enhance social workers' knowledge and understanding of psychotropic medications and the impact on children; (2) improve non-pharmacologic recommendations; (3) develop a monitoring system for those prescribing psychotropic medications; (4) establish best practices for utilization; and (5) make available subject matter experts for consultation.

### Opportunities for Improvement

Through its participation in the CHCS learning collaborative, Vermont identified three opportunities for improvement:

- Concerns about the appropriate use of antipsychotics;
- Adequacy of data to ensure accurate monitoring; and
- Lack of training specific to the appropriate use of psychotropic medications for social workers who are responsible for making medical decisions for children in state custody.

### Quality Improvement Achievements

The state achieved the following goals as part of its participation in the learning collaborative:

- **Implemented a policy on informed consent for the use of antipsychotic medications.** The state conducted outreach to prescribers who had written 10 or more prescriptions for antipsychotics to children in foster care during a 12-month period. Training was then offered for providers on a new policy that requires prescribers to submit a request for consent for the use of antipsychotic medications.
- **Ensured social workers have access to consultation with a child psychiatrist.** A psychiatric consultation program was created leveraging and expanding an existing relationship with the University of Vermont. Under the program, child psychiatry fellows serve in a consultative role and provide social workers with needed clinical expertise.
- **Ensured that primary care physicians have access to consultation from a child psychiatrist.** All pediatric practices in the state now have access to telephone or in-office consultation from a child psychiatrist trained in evidence-based practices.
- **Implemented a continuous quality improvement strategy that is informed by data.** The state's Child Welfare and Medicaid agencies collaborated to maximize the Medicaid Pharmacy Benefit Manager and were able to produce comprehensive reports to support and inform a quality improvement strategy related to the use of psychotropic medication in the foster care population.
- **Tracked overall well-being outcomes of children in foster care.** DCF conducted a review of tools that monitor well-being outcomes and selected on the Child and Adolescent Needs and Strengths (CANS) assessment. The CANS is being rolled out statewide among departments serving children.