



South Carolina Department of Social Services
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South Carolina Department of Social Services

Health Care Oversight and Coordination Plan 2015 - 2019

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INTRODUCTION

South Carolina believes all children must receive quality healthcare which includes regular wellness checks, physical and mental screenings, mental health counseling, dental care and medical care to meet their individual needs. The South Carolina Department of Social Services (SCDSS) is working to set higher healthcare standards in order to ensure all physical and mental health needs are identified including appropriate follow-up and preventative services are provided to ensure a high quality of life for all children served by SCDSS. Throughout this plan, SCDSS has described multiple avenues in which the agency currently meets healthcare needs of the children it serves as well as current efforts to improve the services already in place.

South Carolina Department of Social Services has developed a collaborative team of professionals and stakeholders to serve as a Foster Care Advisory Group with the aim of improving healthcare outcomes for children in foster care. The mission of the advisory group is to champion a system of care that assures children in the foster care system of South Carolina have timely access to and are provided the appropriate and effective medical and mental health care available in a coordinated manner. (See list of members, section VI.)

This plan presents South Carolina's current healthcare policies and practices.

Considerable research has been carried out to document the healthcare problems occurring in children and adolescents in foster care, particularly those covered under Medicaid. Most recently, the report released by Substance Abuse and mental Health Services Administration, SAMHSA , in 2013 provided a comprehensive analysis in Diagnoses and Health Care Utilization of Children Who are in Foster Care and Covered by Medicaid. (1) This report identified the most common diagnoses by age groups.

When the coded diagnoses from all children covered by Medicaid who are not in foster care are compared with children in foster care, interesting findings resulted and are summarized below. It is important to note in this study "diagnoses" are counted and not unduplicated "children;" therefore, a child who has more than one coded psychiatric diagnosis will be counted multiple times. [In this summation only codes related to illnesses, and not Administrative or Preventive Care, are highlighted.] Nonetheless, the statistics are revealing:

- Upper respiratory infections and diseases, (asthma is coded separately) are diagnosed in more than 50% of children 0-5 years, dropping about a third in the 6-11 years group, and reduced further in the 12-17 years ages. If Otitis Media and related conditions are added in over the entire 0-17 years, respiratory illnesses and asthma decline from being the top reason for referral in the youngest age group as the aggregate of psychiatric disorders are increasingly diagnosed.
- In the 0-5 years group only ADHD appears as a significant psychiatric diagnosis, but shows a dramatic difference between children in foster care (8.7%) as opposed to Medicaid-covered children not in foster care (1.4%). In children 6-11 years ADHD, Conduct, and Disruptive Behavior disorders leap to the most prevalent diagnosis in foster children at 33.5%, and increase to 10.6% in non-foster children, where respiratory-related illnesses remain the number one reason for seeking medical care. In the oldest age group, ADHD and related behavioral disorders increase slightly more as a percentage of diagnoses, but absolute numbers may be less as there are less overall numbers of adolescents being seen for medical care.

- In the 6-11 years age group ADHD, including behavior disorders (33.5%), Adjustment Disorders (15.5%), Anxiety Disorders (10.0%), and Mood Disorders (9.5%) are all heavily represented diagnoses in foster children, and are found four times more frequently in the foster care group compared to the non-foster care children. The oldest age group shows a similar diagnostic disparity between foster care children and non-foster care children, but there is an overall significant increase in Mood Disorders diagnosed compared to other mental health diagnoses in both groups.

Comparable data from SC is not available yet, but may be easier to review with forthcoming improvements in the data system. An unsystematic review of non-psychiatric prescriptions in 2012 did question whether there might be excessive antibiotic prescriptions being written for illnesses, such as otitis media, where more recent data would not support the benefit for prescribing these medications. The importance of understanding these statistics directly affects the delivery of care model being used in South Carolina.

The recognition that young children, who are stressed by becoming victims of neglect or abuse, or from disruptions in their lives from being moved from one placement to another, are harmed both physically and emotionally emphasizes the need for a unified medical and behavioral health approach to health care. Chronic stress or multiple acute stressors can lead to dysregulation in the manner in which the stress hormones, such as cortisol, operate. Chronic stress activates multiple biological systems, including the immune system, blood pressure, heart rate, nervous system reactivity, and even the expression of genes. Behavioral consequences include mood dysregulation, difficulty focusing attention and thinking, poor impulse control, and other symptoms, and these problems become more difficult to reverse the longer they are allowed to go untreated. These difficulties, however severe though, can be ameliorated by early and sufficient evidence-based interventions. (2)

In moving to a medical home approach, in particular utilizing a single Managed Care Organization as the point of referral, it leads to the possibility of pediatricians and family physicians functioning as Primary Care Providers (PCP). Pediatricians and family physicians would be asked to treat primarily "medical disorders" in the earlier years of the child's life, whereas psychiatric disorders become more prevalent as the child ages. This bears on which diagnoses PCPs are comfortable with and competent in providing treatment for, and which diagnoses require referral to specific mental health providers (both physicians and non-physicians). PCPs typically feel more comfortable with treating uncomplicated ADHD and moderate mood disorders, but perhaps are outside of their comfort zone and skill set with other psychiatric diagnoses. It is incumbent on an operating MCO to either enroll a sufficient number and diversity of mental health specialists, one that geographically covers the state, or be willing to refer out-of-network, either to private practitioners or to Department of Mental Health clinics. Few private practice child psychiatrists in SC are enrolled in the MCO and are easily accessible for the foster care population except where the psychiatrist is a contracted provider to a group care facility or is associated with a larger entity or clinic which is enrolled. Historically, it has been difficult to locate child psychiatrists in private practice who were will to accept Medicaid, and many apparently require payment at the time of the appointment (An informal poll suggests many will not bill any insurance, requiring the patient to reimburse for services at the time of the appointment.) This situation leaves Mental Health Centers as the primary source of psychiatric care for Medicaid members, but as DMH is carved out of the MCO it has some impact on the fiscal soundness of the Medical Home model. It is estimated that a quarter of primary care visits for children and adolescents were for behavioral, emotional, or developmental issues.

Other often-seen "medical" disorders also require a network of specialists toward whom referrals can be directed or from whom consultations can be obtained. Among other diagnoses presented by SAMHSA, Developmental

Disorders are disproportionately seen among foster children (8.9%) compared to Medicaid recipients not in foster care (3.9%). Because these disorders are not further specified, "developmental disorders" would include some psychiatric disorders in the Autism Spectrum category, in addition to mental retardation and a mixed bag of more rare disorders. Developmental Pediatricians are very few in the state and difficult to access. Additionally, the Medically-Complex sub-group of foster children demands highly-specialized planning and treatment.

It is unclear at this point how effectively the MCO could utilize its roster of Pediatric Psychiatrists to provide assessment and treatment for foster children as consultants to Primary Care Providers; the anecdotal sense is that this consultation is limited, both with the number of Child Psychiatrists accessible (including geographical availability) and the timeliness of appointments. This contrasts with the wider availability of DMH Mental Health Center Child Psychiatrists, although wait times for psychiatric appointments can be long in many MHCs. SCDSS and other State Agency partners need to collaborate to accomplish the following goals:

- Work with the MCO to create a more complete roster of physicians in specialty areas who are "available" in different geographic areas of the state and able to provide appointments in a timely manner, and clarify which General Psychiatrists accept child or adolescent patients; and to make this list more consumer (DSS Caseworker and foster parent) friendly on the website.
- Work with the MCO and the Department of Mental Health to clarify their respective roles in providing Behavioral Health services, and either develop an available roster of private psychiatrists accepting child and adolescent patients enrolled in the MCO or establish a referral relationship between the MCO and DMH to compensate for lack of availability in the private sector.

Displaying a snapshot of the medical needs of SC Foster Children is difficult at this time. Only within the last few months has the South Carolina Department of Health and Human Services (SCDHHS), the Medicaid agency established an "identifier" in their data base that would allow foster children to be studied separately from the much larger group of Medicaid-eligible children not in foster care. Goals include:

- Review the Medicaid claims data for SC Foster Children to establish data on medical needs, including prescription drugs, and providers, and subsequently use this data to guide the MCO in establishing an appropriate and available physician roster for DSS Caseworkers to use.
- Track completion of required medical, behavioral health, and trauma screenings and follow-up assessments to establish a baseline from which to move forward over the next several years. At the present time, tracking this data would require using the new Medicaid "identifier" and cross referencing this by hand with the CAPSS data on points of entry into Foster Care.
- Track prescribing patterns over time and intervene to meet standard of practice goals [See section on Psychotropic Medication Oversight]. Several studies have looked at the prescribing patterns for psychotropic medications. One particular study compares Foster Children with other Medicaid-eligible groups of children; these studies are reviewed in the section on Medication Monitoring.

INVOLVEMENT WITH OUTSIDE AGENCIES OR PROVIDERS IN DEVELOPMENT OF THE FIVE-YEAR HEALTH CARE PLAN

In SC over the past year two groups of outside medical professionals and other Stakeholders have been convened to give input into the 5-year planning process. One area of focus for the **Stakeholders Meetings** was subsumed under "Well-Being," and included Health Care considerations. Goals and recommendations developed in both groups were more appropriately included in other sections of the 5-Year Plan for Foster Children rather than addressing specific details in the Health Care portion of the Plan. General recommendations and goals from its last meeting on 1/14/14 and previous meetings included:

1. To improve communication between DSS, other Child-Serving Agencies, and Providers around health care issues
 - a) To set up a Log-In Web Environment, providing different discussion areas, where county organizations can make comments and publish information and events. It should be run by staff, not directors. The University of SC has the capability to create the website. There would need to be an administration to run and manage it. Trainings could be published on it. Possible tutorials to teach how to use it. Also, e-mail distribution.
 - b) Development and utilization of SCHIEx and other approaches to sharing medical information appropriately among agencies and schools responsible for child's care and education, toward goal of improving continuity of care.
2. Evidence-Based Treatment/ Trauma-Informed Care
 - a) The SC Trauma Initiative—It is imperative that the state is trained in Trauma-Informed Care.
 - b) The Palmetto Association is doing cross-training among agencies. More training for Trauma Awareness for DSS. Further use of the South Carolina Health Information Exchange (SCHIEx) needs to be promoted to see if it can become a viable tool for better health care information exchange and coordination of care for Foster Children.
 - c) Developing a plan to focus on Secondary Trauma, sharing the curriculum. It is across all agencies, not just DSS.
 - d) Continue collaboration between agencies to develop a Trauma-Focused Treatment Plan
 - e) Develop cross-training between agencies DSS and DMH, including the Child Advocacy Center
 - f) Continue the pilot program for Trauma-Informed Care which has been approved by DSS State Office
 - g) Make sure that all partners are included in further planning discussions.
 - h) Trauma-Focused Treatment needs to be a priority with multiple agency involvement, including schools, and over-coming complications in regard to confidentiality needs to be a priority.
3. "Core Values" around "Child Well-Being" need to be clearly established and widely disseminated; Providers need to be framed as "true Partners".
4. There needs to be better training about and more consistent use of the Education and Health Passport with both SCDSS Caseworkers and Providers, and there needs to be greater accountability to ensure its use; the Passport needs to be looked at to determine if it contained all the needed information when children are moved from one placement, school, or physician to another; needs to be linked into CAPSS and easily updated through that portal.
5. Parents need navigators to help them understand the treatment plan and maneuver through the system toward the goal of increasing family support and enhancing family engagement and ensuring future follow-through on child's health care and behavioral health needs.
6. Greater attention needs to be paid to thinking through and preparing the child for any transitions: placements, schools, treatment model or therapist, etc.

7. Measures need to be taken to understand and stem the constant turnover of staff, particularly on the local level, and to understand why vacated positions are not filled more quickly.
8. There needs to be an emphasis on increasing and improving community-based treatment options to reduce dependence on higher cost out of home options.
9. SCDSS needs to conduct research on how well initiatives are being implemented and how well they work, with a focus on outcomes that are clinically-driven and long-lasting.
10. Ultimately, a Coordinated System of Care which ensures Continuity of Treatment is essential.

The **Foster Care Advisory Committee** began meeting in early 2013 and the physician community has been well-represented, frequently including Pediatricians (representing, in part, the SC chapter of Academy of Pediatrics) and the MCO and other clinics, a forensic pediatrician representing the CACs, and child psychiatrists representing DSS and DMH, and has included other behavioral health professionals, representing DMH and Licensed Independent Professionals (LIPs).

This group, in particular, was divided into 3 sub-committees or Work Groups: Access to Care, Trauma-Informed Care, and Medical Assessment. Each of these Work Groups has been charged with making recommendations to the Agency. The most recent meeting occurred on February 19, 2014.

Specific recommendations/goals from the Access to Care Work Group are:

- Communication between DSS, DHHS, the MCO and Providers needs to be improved; this includes where changes are made in billing or payment as well as a way to directly and expediently resolve disputes, both regarding approvals for services and reimbursement issues.
- There needs to be an active and coordinated approach to recruiting physicians and other health care professionals to become enrolled as Providers in the MCO; this includes streamlining applications to be enrolled, publicizing payment schedules to counter perception that reimbursement rates are low.
- Develop a plan for Psychiatric Consultation to be readily available to LIPs therapists PCPs who are managing the child's care (either through a roster of private consultants available by phone, linkage into DMH for consultation, or by DSS directly hiring available consultants); and, incentivize practitioners in rural or underserved areas to enroll in and participate in the MCO (including reimbursement for travel expenses).
- Develop a workforce development plan that could include internships, graduate education, supervision for licensure, training for specific certifications, and loan forgiveness to practice in underserved or high-need areas.
- Foster greater inter-agency cooperation in resolving problems in delivery of health care to Foster Children; this includes creating a climate where Cabinet and Non-Cabinet agencies have incentives to mutually develop solutions, and an effort be made to break through public-private boundaries to create models of care that utilize the best of both systems working together on individual cases (to include psychiatric back-up for private therapists—LIPs—to provide crisis medication assessments and follow-up or to assist with hospitalization when needed, as well as cross-training opportunities).
- Develop a data system which can match the date of the child's removal to location of placement, distance from assigned PCP and Mental Health Center (or alternately a private LIP), timeliness of referral, time of

appointment, completed initial appointments with PCP and DMH(including trauma screening), follow-up assessments scheduled, completion of assessments, referrals for treatment, and initiation of treatment(s); in general, "encounter data" history for each child needs to be better profiled and easier to retrieve to ensure continuity of care and for fiscal transparency.

- Under the Medical Home model through the MCO, the notification of a child being taken into custody needs to be processed through the MCO as the portal of entry into medical care delivery, where the decision would be made whether to screen the child for mental health / trauma through an enrolled provider or to go out-of-network. If it were done this way, DMH could be considered an out-of-network Provider reimbursed by the MCO, rather than fee-for-service directly through the Medicaid Agency as occurs now when referrals are made directly by DSS to DMH.
- A training package is being developed for physicians and other health care providers to train them on standards of care, including standardized assessment tools compatible with the EHR and coordination of care as they relate to children in foster care, with a separate training module for DSS Caseworkers and Supervisors as brokers securing necessary services. These training modules will be developed by the University of South Carolina and be on video, with new workers and Providers trained as they come on line. A third training package will also be provided to foster parents and the child's family of origin or prospective adoptive family on understanding each child's medical needs and assisting in having those needs met.
- The Education and Health Passport will be improved so that it contains all the necessary information to enable the physician to initiate or continue treatment for the child new to that practice. The Health Passport will be incorporated into the DSS electronic case file (CAPSS) so that it remains up-to-date and maximally useful for Providers.

The **Trauma-Informed Workgroup** Recommendations and Goals, many of which have already been started and are described more fully under the Trauma-Informed Care: Current Activities and Initiatives, include:

- Development of a list of trauma screening instruments. The trauma-focused screening protocol, including lists of trauma screening instruments has been finalized and is awaiting interagency approval as of 2/19/2014.
- Develop a Trauma-Informed decision tree to act as a pathway for decision-making. The existing decision tree from Miami can be reviewed. An Assessment Algorithm for Referring to TF-CBT has already been developed.
- Collaborate with SCDHHS to develop a specific Procedure Code and Modifier to enable Providers to bill specifically for screenings and assessments.
- Specific procedure codes for Trauma Screening and Assessment will allow research as to whether or not implementation of completed TF-CBT protocol results in less prescription of psychotropic medication, number of changes in placement, length of time in care, and efficacy of treatment.
- Provide training to DSS Protective Services workers to enable them to do initial trauma histories/ screening.
- Increase expectations for both foster parents and biological families (in absence of TPR) to participate in therapy. DMH and LIPs providers will need to be open to flexible schedules to allow this participation and with DMH, flexibility in serving parents and children residing in different areas at the same site (possibly midway between the two locations; make DSS more responsible for ensuring transportation is available and that Caseworker is involved at Treatment Team meetings.

The **Medical Assessment Work Group's** scope and purpose was to develop a standard of care for initial medical assessments (for which a form was proposed); further evaluation and follow-up through the Primary Care Provider. The Group's scope also included proposing a training model on issues of medical assessment, and to provide input on the matter of consent to and review of medications being prescribed. There was much discussion and a total unanimity of opinion, but a general consensus on recommendations and/or considerations for implementation:

- A standardized protocol for medical screenings, assessments, and follow-up for all children entering Foster Care needs to be in place. This protocol also needs to be mindful of and adhere to EPSDT requirements which will provide a comprehensive longitudinal record for DSS to maintain and use to update the Health Passport. The Protocol should include a standardized developmental screen at one month into care and follow the American Academy of Pediatrics recommendations for wellness visits. A template needs to be offered to Providers which is compatible with the Physician's Electronic Health record
- Three training videos need to be developed to educate on the assessment protocol that encompass enlisting compliance of Primary Care Providers, training SCDSS staff to understand what they need to request and how to follow-up on completion; and for parents, foster parents, and group care workers to understand the requirements and are how to follow-up, as well as to understand their own responsibilities around medications, etc. There is a plan to have these training videos developed through the University of South Carolina. There was further discussion, but no conclusion drawn as to whether these video trainings need to be interactive so that questions can be asked and responded to. How trainings would be provided and how often were discussed: DSS and the Foster Parents Association were mentioned as sharing responsibility to implement.
- "Prospective" reviews and DSS consent were considered to be impractical including psychotropic medications prescribed by Pediatricians or other PCPs. The effort to provide sufficient information to the DSS Clinical Team / Psychiatrist would extend beyond the capacity of the Practitioner and could not be accomplished in a timely enough manner. A consideration for a scaled down model in which DSS Medical staff consent would be needed in certain circumstances, such as for antipsychotics, but it would depend heavily on successfully training all Providers as indicated above. The MCO's existing structure plays no role in training or establishing Standards of Care for its enrolled Physicians, hence viewing the training video and adhering to the standard would still be up to the individual Physician.
- "Retrospective" review of prescriptions is possible utilizing Medicaid and MCO encounter data with DSS Clinical Team / Child Psychiatrist providing feedback. This could incorporate a review of various parameters regarding medications, poly-pharmacy, dosing limits, etc.
- Psychiatric Consultation needs to be readily available to Primary Care Physicians working with Foster Children, not only around medication concerns, but also regarding diagnoses and treatment / referral recommendation.
- If point-of-service Informed Consents are required for each change in medication, the adult accompanying the child must be empowered to give consent.
- The Physician doing the initial evaluation needs more information than they often have regarding past history, family history, medications, etc. At the Family and Child assessment center in Greenville, they require the biological parent to come to the initial assessment, which may not always happen and is not the standard everywhere. This is more difficult if children are placed a distance from their home county. Assessing physicians would likely need to have access to previous claims / encounter data, but this helps only if the child was previously on Medicaid. This is recognized as a tough issue that needs more systemic planning.

- Trainings on the Medical Assessment Protocol can be merged with trainings on medication issues and the Consent Protocol required, as well as reiterating EPSDT requirements.

MEDICAL CARE

CURRENT ACTIVITIES / INITIATIVES

SCDSS

Foster Care Screening Schedules in Current Practice at SCDSS

1. An initial assessment by a physician is arranged and completed within five working days of a child's entry into foster care. When possible, the child's regular medical provider is utilized. The Comprehensive Medical Assessment (Current SCDSS Form 3057) is obtained from the physician and filed in the child's record and a copy is filed in the Education and Health Passport (Current SCDSS Form 30245). All follow-up services are arranged and coordinated with medical providers as indicated by the health professional.
 - Child will be taken to a PCP, preferably a pediatrician, to complete an initial screening.
 - Child will be taken to the Department of Mental Health (SCDMH) or a Licensed Practitioner to complete a mental health assessment to include screening for trauma within 24-48 hours and no later than 72 hours.
 - "An additional appointment will be scheduled (at the time of the first visit) no later than 30 days from the date of the first appointment to complete a comprehensive assessment and follow Early Periodic Screening, Diagnosis, and Treatment (EPSDT) protocols."
2. DSS case managers maintain monthly face-to-face contact with each child in foster care for the purpose of assessing appropriateness and safety of placement including the monitoring of illnesses, incidents or injuries; assessing and monitoring progress of child's developmental, educational, medical and social needs; and ongoing services.
3. The above outlined contacts are for the purpose of:
 - Assessing provider's ability to maintain a safe and appropriate placement for a child and identifying any services the provider may require to facilitate caring for the child and meeting the health needs of the child
 - Sharing and documenting information of unusual injuries, incidents or illnesses of a child in foster care with the licensing worker and other agency personnel who have an interest in the foster home
 - Reviewing the Education and Health Passport to ensure it is kept up to date and policy is updated.
4. If during the mental health assessment, mental health services and counseling for trauma-related issues are identified, services are to be provided by the appropriate providers, either through a Licensed Practitioner or

the SCDMH.

5. Health Screening Frequency: Currently, children in foster care are provided on-going medical, dental and vision screenings according to the federally-approved standards (EPSDT Guidelines - Physician's Provider Manual, Section 2, pp. 62-63). Effective July 1, 2012, South Carolina Department of Health and Human services increased the screening schedule to include eight preventive visits for recipients under the 21 years of age in addition to those specified by the EPSDT Periodicity Schedule. SCDSS is changing policy to reflect those changes and to require that children in SCDSS care get the maximum allowable wellness visits per year.

SCDSS Informed Case Planning and Referral / Linkage to Services

Service planning includes assessing for safety and risk of abuse and neglect for children in foster care, the completion of a thorough needs assessment that identifies the services the family needs for reunification, and the specific medical and behavioral services the child needs while in an out-of-home placement. Children, regardless of age, have specific needs that must be included in the plan. Planning for children, age 13 to 21, must include the provision of services to prepare the child for independent living.

- The child's plan must be developed within 60 days of the child's entry into foster care. The plan includes sections on the developmental, mental health, physical exam results, dental and vision exams, psychotropic and general medication regimes and prescribed follow-ups. The assessment of these evaluations should assist the caseworker with the development of a plan of services to meet the child's specific needs. Even though there may be a delay in the court hearing, the assessment and case plan are completed with the information available.
- Team decision-making requires that service planning participants include the parent(s) or guardian from whom the child was removed, the non-custodial parent(s) (if available), the child (if age-appropriate), and any agency personnel or other individual who will provide services or support needed to implement the plan. An ongoing diligent search must be made for any absent parent (specifically biological and/or legal fathers) upon the child's initial entry in foster care. The Guardian Ad Litem assigned to the child is involved to the maximum extent possible in planning and evaluation in accordance with the Guardian's legally mandated duties (S.C. Code of Laws 63-11-510, 530, and 540). The foster parents are involved in team decision-making as related to the needs of the child in their care and are participants in any team meetings. Service planning is documented through the development of a comprehensive placement/treatment plan for the child and parent in the CFASP. A permanent plan is developed for each child in foster care prior to the Removal Hearing (refer to the DSS Policy & Procedure Manual, Section 818.05).
- Service planning requires that the CFASP be updated at least every six months, or when the case evaluation indicates a change in circumstance, or when the time frame expires, or when changes in the case circumstances occur (such as new allegations). Any needed updates not consistent with the court order must be reviewed by the court unless parents agree to the revisions and the revisions are approved by the court. New allegations and findings which require additional services will require

- court sanction if the parents will not agree.
- Foster Care staff obtains current information on status of the outcome of services being provided based on the specific needs of the child. They conduct at least monthly follow up with providers for updates on progress/success in addressing the physical, medical, educational, trauma related and other mental health needs; follow up as needed to assure receipt of quarterly written reports for the purpose of evaluation and providing copies of reports to GAL and FCRB; and revise the CFASP as necessary, i.e., indicating when needs have been met or alternative or additional services are needed. Foster Care staff ensures the Education and Health Passport, CAPSS and child's SCDSS paper case file are updated with the most recent medical information.

Also, a Case Management Services Plan (CMSP) is developed for the child, family and providers within 60 days to complement the CFASP. For those children identified as having behavioral health issues, the plan of service frequently includes a comprehensive evaluation, diagnostic (and, in the future, a trauma history/screening as well as a trauma assessment if indicated), individual therapy, family therapy, Rehabilitative Behavioral Health Services (RBHS) such as behavior modification, rehabilitative psychosocial services, and/or family support. SCDSS assesses all the child's needs within the home, community, school, etc. Hence, the SCDSS workers partner closely with the schools, SCDMH, Department of Juvenile Justice, Department of Disabilities and Special Needs, psychiatrist/therapist, community non-profits and private providers to address all areas of the child's life in order to stabilize the child and reunify them with their biological or an adoptive family. The contact standards and service planning extends beyond the CFASP. The SCDSS uses a team approach to serving the child in foster care experiencing an emotional disturbance.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES CHIPRA QUALITY DEMONSTRATION GRANT

South Carolina was one of 10 grantees selected in 2010 to participate in this federal quality demonstration grant. The grant is aimed at establishing and improving the quality of children's healthcare through measures of quality, promotion of health information technology, and evaluation of provider-based models. South Carolina was awarded \$9.2 million for this demonstration project which continues until February 2015.

The South Carolina grant has four key goals:

1. **Quality:** demonstrate that newly-developed quality indicators can be successfully utilized in pediatric practices;
2. **Technology:** share key clinical data through a statewide electronic quality improvement network;
3. **Innovation:** develop a physician-led, peer-to-peer quality improvement network; and
4. **Pediatrics:** expand the use of pediatric medical homes to address mental health challenges of children in our state.

The CHIPRA project represents a unique opportunity for South Carolina pediatricians to help develop quality improvement tools that will lead to better health outcomes for current and future generations of patients. The grant also provides support to participating practices. These include:

- Assistance with practice transformation to integrate behavioral health into a pediatric office;
- Support to achieve at least a level 2 NCQA certification for a patient centered medical home;
- Credit for Part IV of maintenance of certification credit, with no tuition charges;
- Assistance and resources to meet the practice needs;
- Free consultation and assistance to ensure existing health information systems (EMRs) are linked into the state quality improvement network; and
- Quality improvement coaching and support in implementing quality improvement projects.

Eighteen primary care pediatric practices across South Carolina were selected as part of our grant to improve patient care through the use of clinical quality measures and health information technology. South Carolina has a heterogeneous mix of practices; they vary in location, practice size, integration of mental health and are at various stages of electronic medical record adoption. In SC, unlike some other states, the focus of the CHIPRA grant is not specifically on the Foster Care population, but a number of Foster Children are being served.”

Each practice identified a lead practitioner to implement the quality improvement efforts within the practice, along with an internal QI team. In addition to the support outlined above, we conduct semi-annual Learning Collaborative sessions which coincide with the SC Chapter of the American Academy of Pediatric meetings. The Learning Collaborative is designed to introduce quality measures, mental health and patient centered medical home concepts. QTIP staff also provides assistance to the practices to support their learning and quality improvement methods; examples include: on-site peer-to-peer visits to the practices, quality reports, academic detailing, assistance on electronic medical systems, monthly conference calls, and various resources.

QTIP is a partnership between the SC Department of Health and Human Services, the South Carolina Chapter of the American Academy of Pediatrics, the University of South Carolina – Office of Research and Statistics and the School of Pharmacy, Care Evolution, and Truven Health Analytics.

An ongoing effort is directed toward obtaining continuing funding for the CHIPRA initiative and gradually expanding the model to a significantly greater number of Pediatric practices; if the grant is re-funded, SCDSS through collaboration with SCDHHS, may have a greater opportunity, acting as the child’s health care broker, to selectively funnel more Foster Children toward willing practices involved directly or benefitting from the health care model developed through the CHIPRA grant who have expressed an interest in working with Foster Children, with the goal of working toward a uniformly high standard of care for this population. Such practices could serve other geographic areas in a way similar to that of the successful Family and Child assessment Center in Greenville described below.

FAMILY / CHILD ASSESSMENT CENTER

This is a new clinic in the Greenville, SC, area where children coming into Foster Care receive a complete physical assessment within the first week in placement. The clinic has a close working relationship with the local Mental Health Centers, which have responded with making the 48 hour mental health assessments and trauma screenings a priority. The pediatrician at the clinic also serves in a forensic capacity at the local Child Advocacy Center and now forensic exams in cases of child sexual abuse will be completed within 48 hours, aiming toward reducing contamination from any Mental Health screenings or assessments prior to the forensic exam. In general, the three entities work well together, and work closely with SCDSS. The philosophical approach at the Family/Child Assessment Center focuses on seeing the child quickly, but also

obtaining medical releases quickly from the biological parent so that complete medical history on the child can be gathered at the start of any involvement, and then filling gaps and making corrections to incomplete or misleading records. The Center involves both the biological parent and foster parent in the assessment process, particularly assessing the biological parent for mental health, substance abuse, domestic violence, and other stressors. The intent of the Center is to establish a Medical Home which can follow the child throughout their placement, unless a change in placement creates an unworkable distance issue. The primary problems have been those of transportation issues if placement is changed, and Foster Parents desire to take the foster child to the physician they are already using for other children.

MEDICAL UNIVERSITY OF SOUTH CAROLINA FOSTER CARE SUPPORT CLINIC

The **Foster Care Support Clinic (FCSC)** is a primary care medical home for children in foster care in the three-county Charleston, Berkeley, and Dorchester region. Established in 2009, the clinic has undergone significant growth and now cares for over 400 children, with 10-15 new cases accepted per month. The FCSC is a contracted collaboration between MUSC and SC DSS. The FCSC is affiliated with MUSC and has emphasizes serving medically complex children and for that sub-population will accept patients from anywhere in the state where transportation is not prohibitive. In addition, the clinic assesses children who have required multiple placement changes to work with DSS to interrupt this cycle. The clinic has a working relationship with medical specialty providers at the hospital, allowing it to meet the multi-faceted needs of children with complex behavioral and medical needs.

The FCSC provides comprehensive evaluations for children entering care, as well as serving as a primary care medical home for children in out of home care. The initial assessment for all new patients includes an initial evaluation and a one-month follow-up, giving the provider time to obtain and review records and the foster family and other care providers a chance to better understand the child's needs. Children adopted or reunified have the option of continuing to receive care within the FCSC. As part of the comprehensive assessment, many behavioral health problems are treated within the FCSC with support from community therapeutic agencies, child psychiatry and developmental pediatrics. Children with significant medical or behavioral health needs are reviewed at quarterly Intensive Treatment Team (ITT) meetings. These meetings typically involve any health care providers, social services, community agencies involved, school personnel, foster parents and biological parents. In addition, the FCSC provides training and education for foster parents and DSS staff that are counted toward licensure and continuing education requirements.

The short-term goals of the FCSC are to expand clinical services with additional primary care and mental health staff. Additionally, the clinic has begun to gather data to establish whether the intense coordinated services through the clinic have been able to decrease overall costs compared to the more fragmented care before referral, and whether this coordinated medical care can reduce placement disruptions and length of stay in Foster Care.

PALMETTO COORDINATED SYSTEM OF CARE (PCSC)

The PCSC is being developed by the South Carolina Joint Council on Children and Adolescents (JCCA). This body includes the directors of the child-serving agencies of the state, family members, and other interested and involved organizations. A Memorandum of Agreement (MOA) has been negotiated among eight child-serving agency directors and three family members that detail the responsibilities, the monitoring, and oversight of the PCSC.

The PCSC is taking an evidence-based approach that is part of a national movement to develop family-driven and youth-guided care, keep children at home, in school, and out of the child welfare and juvenile justice system. A system of care incorporates a broad, flexible array of effective services and supports for a defined population that is organized into a coordinated network, that integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive policy and management infrastructure. An important PCSC goal is the expansion and maintenance of coordinated and effective community based services. PCSC will also create partnerships between public and private providers of services that target children, youth and their families in a multi-agency, multi-disciplinary system of services.

The implementation of components of the PCSC is expected to begin in October 2014 with full implementation targeted for July 2016. The PCSC is being built on the foundation created in 1983 by the establishment of the Continuum of Care and the many efforts since to improve behavioral services to children and youth through local System of Care grants and the recent state level planning grant.

The target population is children and youth, including significant numbers of children either in or formally in DSS Foster Care or who are in or at risk of out of home placement. Ongoing work of the PCSC will be to further operationalize this definition according to agency priorities. Timely and appropriate services will lead to more community and in-home placements that are better for children and with lower costs that ensure that the state has greater capacity to expand services to truly provide a system of care.

Full implementation of the PCSC will eliminate barriers to services and increase the array of services for children and youth with emotional and behavioral disorders. With full involvement of families in family-driven and youth-guided care, children have a greater likelihood of achieving healthy and functional lives as successful, responsible, productive citizens.

EMOTIONAL SUPPORT FOR SCDSS EMPLOYEES

Discussions during the development of the 5-Year Health Care plan pointed to the need to address the high burn-out rate for DSS staff, particularly those on the front line. The issue was raised that the stress levels are so high and the situations encountered often so traumatic that there is a need for emotionally supportive opportunities to be available for staff. Not only would this translate into their personal lives, but staff turnover at the Agency might decrease and there would be a trickle down benefit to the Foster Children. To date there is no statewide initiative in this area, but one program in Simpsonville utilizes volunteer chaplains to offer supportive counseling to DSS staff who are overstressed or when an intense event has occurred. Efforts need to be undertaken to support these types of interventions in other regions.

OVERALL ADOPTION OF THE MANAGED CARE ORGANIZATION MODEL FOR FOSTER CHILDREN IN SOUTH CAROLINA AND THE ROLE OF THE DEPARTMENT OF MENTAL HEALTH IN BEHAVIORAL HEALTH

CURRENT ACTIVITIES/ INITIATIVES: MCO

Implementation of a more integrated, coordinated care management model is designed to unite the child's entire support system (primary and specialty care professionals, caregivers, case workers, providers, care managers, various community agencies) in promoting healthy foster children in safe, nurturing, stable and permanent homes. Assessing, treating and maintaining health and well-being and expecting better outcomes also play a crucial role in promoting adoption and other positive permanency outcomes for children in foster care. Following is a description of the current South Carolina healthcare delivery system

SC has elected to move all foster children into Medical Homes under the MCO model (previously SC was also utilizing Medical Home Networks, too.). All new children entering foster care are assigned to one particular MCO currently serving approximately 80-90% of all children in SC Foster Care. The primary exceptions to enrollment in an MCO are children placed in Psychiatric Residential Treatment Facilities, who remain fee-for-service using a bundled rate. Some of the Medically Complex waiver Foster Children, in particular, remains with a different MCO. All of the MCO-enrolled foster children have been assigned a Primary Care Physician, but foster children who have been admitted to a PRTF do not have an outside membership in an MCO and their overall care is not coordinated by a PCP.

A formal contract between DHHS and the MCOs has not been signed as of this date, but the draft contract addresses specifically many of the Federal concerns around meeting the health care needs of foster children. Briefly, some of these key provisions in the contract are:

- A. Core Benefits of SC Medicaid MCO Program includes:
 - Services that are sufficient in amount, duration, and scope to achieve the purpose for which the services are furnished. . .in accordance with standards as defined in the state plan . . . up to the limits as specified in the minimum service requirements.
 - Service limits such as a drug formulary may be implemented; however, there must be a method to cover drugs outside the formulary if they are determined to be medically necessary.
- B. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Well Child Visits shall include:
 - Written procedures for notification, tracking, and follow-up to ensure EPSDT services will be available to all eligible Medicaid Foster Children and that required protocols are followed.
- C. Emergency and Post-Stabilization Medical Services:
 - Prior authorization is not required for these services.
 - The contractor will be responsible for payment to Providers in and out of the network service area for these services.
- D. Medical Services for Special populations, Including the Chronic/ Complex Special Needs Population:
 - Mechanisms shall be implemented to assess each Medicaid MCO member identified as having special health care needs.
 - Determination will be made to assess the need for any enhanced services required to maintain their health and well-being, and allow direct access to specialists appropriate for the child's condition and identified needs.
- E. Psychiatric Services beyond services provided through the MCO, which will be reimbursed directly by the Medicaid Agency as fee-for service shall include:
 - Hospital services provided at a Psychiatric Hospital.

- Physician services provided by the Department of Alcohol and Other Drug Abuse Services.
 - Services provided by the Department of Mental Health (per outline in the MCO Policies and procedures Guide.)
- F. Care Coordination and Targeted Case Management requires:
- The MCO will ensure that each Foster Child has an ongoing source of Primary Care appropriate to his or her needs and a person or entity formally designated as primarily responsible for planning, directing, and coordinating the child's health care services, including preventive care and referral to specialty providers.
 - The MCO will be responsible to have a system for coordinating the child's health care delivery that ensures the child's needs are met and avoids duplication.
- G. School-based Services shall include:
- Providers of these services, primarily the Department of Mental Health, shall continue to be reimbursed on a fee-for-service basis, but the MCO shall develop procedures to promptly transfer medical and developmental data needed to coordinate ongoing care through school-based services.

GOALS/ OBJECTIVES: MCO

Moving to the MCO model for delivery of healthcare services to foster children presents a number of hurdles, at least in its early stages. The goal of each child having a "true" patient-centered Medical Home is far from met. While almost all the Foster Children have a designated Primary Care Physician, many elements that would constitute a Medical Home are still unachieved. One key concept is Care Coordination, but developing the buy-in from Pediatricians and Family Physicians to accept this as a major role is difficult. It would be useful to push Physicians to seek accreditation as Medical Home providers, but this is voluntary and does require some time and effort. Developing a "Standard of Care" for all Foster Children scattered among the multitude of Physician offices or clinics is a daunting challenge. Their own professional organizations provide guidance, but the MCO itself does not push this concept with its enrollees. The MCO currently functions primarily as a "payer" for services, rather than setting any standards for the services paid for, with the Prior Approval function seemingly being more one of fiscal management. To that end there is very little overall "management" of the system by the MCO or DHHS. They both could send out email bulletins to Providers, but freely admit that many will not read them and they may not influence practice.

As it is, the current system is complex and suggestions have been made that (parent) Peer Support Services be available to assist parents or foster parents in ensuring that the needs of the child are being met. At another level, a series of video training modules is to be developed: one for physicians (PCPs) to help them know what DSS requires medically, and allow them to better understand the array of services, the necessity of and protocols for informed consent, particularly around medications; a second module would train Caseworkers on what is required and how to obtain it, including the trauma screenings and assessments; and a third module would be directed at parents and foster parents to help them advocate for and follow through with meeting the child's medical and behavioral health needs.

One potential approach would be that DSS as the "broker" of health care for Foster Children could engage in an effort to locate a network of MCO-enrolled Physicians who are most invested in serving the Foster Care population and who are willing to adopt some consistent standards of care consistent with a good Medical Home model. It is suggested elsewhere that the CHIPRA Grant currently operating in S.C. could be a model to replicate and re-target its focus on Foster Children, particularly with its emphasis on enhancing Behavioral Health in a Primary Care setting.

Likewise, the Medical Home model is more effectively carried out in two limited programs (also described elsewhere in the Plan) in the state, specifically delivering medical care to Foster Children, the Family/ Child Assessment Center in the Greenville area and the Medical University of S.C.'s Foster Care Support Clinic. Developing similar programs in other areas of the state would enhance the overall delivery of care.

The MCO model continues to face challenges internally in expanding the numbers and distribution of enrolled Providers, particularly in the Behavioral Health arena. Understandably, the problem is complex. S.C. does suffer from an overall lack of resources, and resources which do exist are concentrated in large urban centers. It has been pointed out that the roster of Psychiatrists and Pediatric Psychiatrists on the roster of MCO-enrolled Physicians seems large at first glance, but these resources often appear somewhat illusory and, at best, hard to utilize. But the MCO doesn't keep statistics which can help define the level of difficulty in obtaining private psychiatric care for Foster Children, nor are we able to access statistics on the number of Foster Children seen by private Psychiatrists through the MCO. (The current developing of a Foster Care Identifier in the Medicaid system may make this easier, as the MCO cannot separate Foster Children from other Medicaid-insured children as yet.) I was told the identifier is live now. SCDSS Caseworkers are aware of Mental Health Centers as default providers when barriers arise with MCO-Private Psychiatrist accessibility, but accessing DMH contains its own set of problems, too, particularly with regards to delays in getting appointments. Discussions with the MCO indicate they are formulating a plan to make these behavioral health referrals smoother, but this must also include a "true" roster of available professionals, both Psychiatrists and other mental health professionals, a roster which is user friendly.

In addition, there need to be improvements in the way services receive prior approvals, such that the process addresses patient needs and evidence-based interventions without being burdensomely complicated for patients and providers alike. An effort is underway to develop new procedure codes for Trauma Screening/ Trauma Assessment/ Trauma Treatment services which would have them recognized as specific services in the array of services included in the State Medicaid Plan. These would set frequencies needed for certain evidence-based services at a higher number than the standard MCO-established Prior Approval of 6 encounters per authorization (a situation which can cause delays and disrupt the continuity of care). At the same time there is also some impetus to increase the capitation rate for children in foster care as it is reviewed. Providers now complain that there are difficulties in getting authorizations signed by PCPs and back the Providers and then to the MCO. They express concerns that when Foster Children are moved from one placement to another, it may take a period of time before they see their new PCP, and authorizations to continue treatment may be held up, creating a loss of momentum in the therapy setting to the point of threatening previously-achieved gains.

Independent Practitioners complain of a lack of warning or lead time when either the Medicaid Agency or MCO institute changes, something which could maybe be improved by more regular information bulletins further in advance from both. Ease of enrollment in the MCO, particularly for newly-licensed LIPs, is a continual frustration, made more difficult by the need to become Medicaid-enrolled first, rather than having a coordinated, one-stop effort to assist new potential Providers in getting over the hurdles and thereby increasing the available provider pool. I spoke with a Behavioral Staff person about enrollment today- the issue is on their radar but no changes discussed yet. There has been a chronic complaint that there is no one for LIPs to turn to when they have a question or disagreement with the MCO; fixing this may be helped with the addition at DHHS of a liaison staff member recently brought on board. There is a new behavioral health manager at the MCO, which could address this issue.

Another concern is providing therapy services in rural areas. Much discussion has been heard about the need for incentives or structural enhancements to encourage LIPs availability in many outlying areas. One suggestion which has been floated has been to encourage Pediatricians or Family Physicians to bring part-time LIPs therapists into their offices so that they can set up there and see patients through an entire day, removing the impediment of having to locate multiple office spaces on their own. Other incentives discussed have been loan forgiveness or payment to acquire licensure for therapists willing to focus on underserved areas. Enhanced reimbursement and payment for travel expenses have also been brought up. All this is in the discussion phase, but needs resolution.

There remains, however, a major issue for non-medical providers of behavioral health services, as well as for Primary Care Physicians, in being able to obtain Psychiatric Consultation; Pediatricians have clearly described this as a problem. Two types of consultation are requested: one involves doing face-to-face evaluations of the child, with recommendations for treatment or initiating treatment that should be driven directly by a Psychiatrist; the second is phone consultation to discuss concerns and/ or recommendations, some of which might deal with medication decisions for PCPs or questioning the need for emergency hospitalization. The first needs to be more readily available for the safety of the child and the second could help reduce the need for more costly evaluations. Finding a way to reimburse for phone consultations where the patient is never seen by the consultant is necessary unless the MCO creates a position for a dedicated consultant in-house. Tele-psychiatry as used by the Department of Mental Health is an excellent potential model and is discussed further below, but independent Providers often might not have the necessary technology.

To date Case Management services, although a part of the draft contract, provided by the MCO are limited, and the overall Care Coordination through so many individual physicians' offices seems an unlikely avenue to achieve what is needed and required. Lastly, data collection is not integrated among PCPs and various service providers, but data is needed to drive planning for any systemic changes. Improved collection of Encounter Data seems possible now that a Foster Care Identifier has been incorporated into the Medicaid data base. All of these concerns represent areas where there is a need for discussion and reform in the more immediate future.

GOALS/ OBJECTIVES: THE ROLE OF THE DEPARTMENT OF MENTAL HEALTH

The split system with DMH and Psychiatric Residential Treatment Facilities remaining carved out of the MCO leads to confusion over responsibility and where Caseworkers should look for services. Any ultimately effective system of health care delivery for Foster Children (as well as other groups) in an environment of such limited manpower resources requires that the public-private barriers be broken down and partnerships be established, especially between DMH and the private MCO-funded Behavioral Health community. Mental Health Centers have typically been resistant to assisting with provision of care to any patient who is also receiving care from a private provider, citing reasons, such as not wanting to risk recoupment from Medicaid because of duplication of services/ billing; preferences by DMH Psychiatrists that they provide or supervise all services when they are involved, lack of capacity for DMH psychiatrists to allocate time for any but patients admitted full-time to their care; inability to truly coordinate care with outside therapists, and sometimes the issue of the child and family living in different catchment areas. This thinking ignores the fact that Foster Children are often complex trauma cases which need multiple resources, some of which are not available at the local Mental Health Center and some of which are not available privately. Cooperation is essential.

Extensive discussions were held in developing this Plan as to how the roles for DMH should be defined and what future directions might be most adventitious when planning for Foster Children.

Two things are clear at the start: first, behavioral health services for all children in the state are now more widely available through Community Mental Health Centers serving each county than through an uncoordinated, geographically scattered array of private providers (both in and out of the MCO networks). Second, the plan for Project BEST to train an increasing number of therapists who can provide evidence-based trauma interventions is strongly oriented toward increasing the number of those therapists in Mental Health Centers as opposed the private LIPs providers. These factors would seem to make DMH a major player.

In addition, it appears to be impossible for the MCO to identify children as members quickly enough that any of the 72-hour trauma screenings would ever be coordinated by the PCP. This would leave CMHCs continuing in their role of providing these screenings indefinitely. (DSS Caseworkers do sometimes seek trauma screens from private LIPs when no one is available to do it at DMH.) When there is a positive or inconclusive trauma screen, a full assessment needs to be completed and available to DSS prior to the 30 day staffing. Mental Health officials have expressed the preference to continue the assessment at the same clinic if the child has not been relocated from an initial temporary placement. Their feeling is that continuity of care is likely to be better where there are as few changes as possible. They are more than willing, though, to refer out less serious cases which can be managed by the LIPs therapist and PCP, but feel they are in position to better serve cases of complex or severe trauma. Other factors have to be considered, particularly when intensive treatment is recommended. Trauma-Focused CBT, for example, requires a very intense commitment to bring the child in on a regular basis, and the caregiving adult needs to be part of the treatment sessions. This is a problem where foster parents have a job where taking off that much time would not be allowed. Foster care payments can be around \$600 a month, necessitating another source of income. There is currently no incentive pay for foster parents to be involved in the therapy. The net result is a need for after hours and weekend therapy hours, something much less available at Mental Health Centers than in the private community.

DMH is also willing to give priority status for new appointments to Foster Children leaving Psychiatric Residential Treatment Facilities, expressing a willingness to set up appointments as soon as the county for placement is decided on, the same way they would handle discharges from acute care. These children also might not have been enrolled by the MCO and assigned a PCP before an appointment is needed.

How to make best use of both LIPs providers in the communities and Mental Health Center therapists in the most efficient child-centered way is the challenge and opportunity in front of us. There has been some feeling that the MCO should treat DMH as they would any other out-of-network Provider (possibly through an enhanced capitation rate for foster children) and provide Prior Approvals and reimbursement for services rendered. If DMH does not continue to be reimbursed on a fee-for-service basis, they would prefer a capitated rate for Foster Children referred to them for treatment, such they would in control of the service being delivered.

There is a plan being put forth that Seriously Emotionally Disturbed child identified as the initial target population for the **System of Care Initiative** (some of whom would be Foster Children, but others might be clients of the Continuum of Care or DMH) would be covered under a Behavioral Health MCO separate from any coverage for physical health issues. Questions remain as this was a preliminary discussion: would the proposed BH-MCO be just targeted toward the 5% most severely emotionally disturbed children who are the initial focus of the **System of Care** or would it be more inclusive, perhaps even covering all Medicaid-enrolled MCO children. The emphasis in the CHIPRA grant and with DSS with embracing managed care has been to try to integrate care between the physical and behavioral health domains. How would this objective be preserved? It is clear that the current MCOs through their enrolled physician PCPs have not done much so far to case manage the needed behavioral health services and the majority of this care seems to by default fall back on the Department of Mental Health. Bringing PCPs up to

speed on their role in identifying and managing the behavioral health needs of their patients—a key function in the CHIPRA grant with its limited number of practices—will be a very long process. This argues, as far as Foster Children are concerned, for seeking Pediatric practices willing to accept behavioral health mentoring and making the preferred as providers for these children. But how would a BH-MCO be operationalized? Would its “gatekeeper” role favor Mental Health Centers more than private providers, or not? How would this be decided?

The problem of needing child psychiatric consultation for foster children who are not active patients at a Mental Health Center was discussed. As noted DMH has been unwilling for a number of reasons to bring children into the Centers, and open a chart in order to provide one-time consultations, without the expectation for any continuing involvement. Phone consults doctor-to-doctor have not been considered because of the lack of any payment mechanism and the time pressures on Center Psychiatrists. These discussions developed a more elaborate possible model for psychiatric consultation to Primary Care Physicians and LIPs Providers working with Foster Children. Mental Health would be willing to look at using its community tele-psychiatry program to reach out to PCP offices. This requires installing a T-1 line at the physician's office and paying a \$300-400 a month charge. The suggestion is that this could be piloted in several offices which agreed to accept larger numbers of Foster Children in their caseload, specifically questioning whether this could be tied to the CHIPRA grant clinics going forward, if the program is re-funded and expanded with a foster care focus. There are other large pediatric practices not among the CHIPRA grant providers who see significant numbers of foster children and might be even better initial sites.

As it stands now the small number of Pediatricians involved in the CHIPRA demonstration grant do have available by phone consultation with a Child Psychiatrist working part-time with the Department of Health and Human Services. There is no tele-psychiatry involved, so that the child patients are never seen by the consultant, and the DHHS Consultant cannot provide any treatment if she felt direct care by a Child Psychiatrist was indicated.

In addition, tele-psychiatry selected clinics/ offices could develop a tie-in with LIPs Providers in the area, who could also benefit from the tele-psychiatry and phone consultations. Face-to-face consultations could be reimbursed through whatever model of reimbursement being used by DMH augmented by payment to the physician requesting consultation. A mechanism would need to be found to pay for consultations between providers where the patient wasn't seen, as well as a proposal for reimbursing the clinic requesting the consulting for time and ancillary staff. Tele-psychiatry could also be possible with dedicated Foster Care clinics. It is known that the MCO also has on the table a plan to provide child psychiatry consultation. Foster Children represent a small minority of the MCO enrolled children and spreading the cost to have a statewide consultant for all children under the MCO might be an effective option if that person could also refer for treatment by a child psychiatrist on an urgent basis, if needed.

It would be advantageous for the State to utilize the National Network of Child Psychiatry Access Programs, (http://web.jhu.edu/pedmental_health/nncpap.html) whose mission is “the development, sustainability, and quality of child mental health and psychiatry access programs designed to address the mental health needs of children and adolescents within the primary care setting.” They have a wide data base for programs in other states which offer a variety of models to address this problem. The Network has a number of philosophical positions congruent with those of SC Agencies, including support for Medical Homes which allow behavioral health services to be provided more cost-effectively in primary care practices. The Network will provide consultation to states during both the planning and operational stages.

The opportunity to think creatively to create a climate for better public-private partnership is key to reaching a vision of the highest standard of health care for Foster Children in SC.

EDUCATION AND HEALTH PASSPORT

SCDSS policy (818.05) requires that a child's health and education record is reviewed and updated, and a copy of the record is supplied to the foster parent or foster care provider with whom the child is placed at the time of each placement and is supplied to the child at the time the child leaves foster care (see attachment). The Education and Health Passport was created to facilitate the gathering, transfer, and review of such a record.

The Passport is designed to keep recent information regarding education, health, and family/adult/community connections easily accessible and organized. It is used to aid foster care providers when they are performing a child-specific function (e.g. enrolling a child in school, taking a child to routine medical/mental healthcare, maintaining important family/adult/community connections) and need to share information about the child in foster care.

Items included along with the Passport will include the child's educational grades, school records, Medicaid Card (or any other insurance providers), developmental assessments, records or assessments from child care providers and immunization records. Immediate healthcare needs and current health information are identified in the Passport to include prescribed medications - name of medication and name of the physician; primary health or mental health conditions; and physician or other current health service providers (medical, therapist, dentist and other providers).

This Passport is initiated when the child enters foster care and maintained throughout the child's involvement in the foster care system. It will accompany the child to all school and medical/dental meetings. Teachers, school personnel, doctors, dentists, mental healthcare providers, vision care providers and other healthcare providers add or correct information on the form, which is updated after each visit. This new information is to be shared with caseworkers at visits with foster parents. Keeping the Passport current is the joint responsibility of the agency and the foster care providers.

This document is to be used to facilitate consistent and thorough communication between SCDSS, all service providers, and the child's family/guardian(s). A copy of the Passport and copies of all necessary documents and information are maintained in the child's case file and are reviewed every six months. Copies of recent medical or education documents are obtained and maintained in the case file, as are education documents. Compliance is a problem, both with foster parents retaining, using and transferring the Passport appropriately, but also with it being updated in a timely fashion by Caseworkers. The plan is to digitalize the Passport and make it a part of the DSS case record in CAPSS so that it can be updated and re-issued more easily. Supervisors need to include its use as part of supervision, so that the case manager will have a priority to make sure all medical information and a copy of the Passport is in the child's record and that medical information is updated in CAPSS and that the Passport and related information accompanies the child if there is a change in placement or when the child is discharged from foster care.

Information regarding family/adult/community connections for the child is obtained during the family meetings and other contacts and is recorded in the Education and Health Passport. How and with whom these connections will be maintained (e.g. frequency of contact, location) is the joint decision of the agency, foster care provider, and, if appropriate, the child and parents. Safety of the child is paramount in determining connections to be maintained.

Medical records for the child's case record must include a section to record and keep all medical information on the child. The record must include a copy of the Education and Health Passport, copies of all test results available to the agency, medications, immunizations, copy of Medicaid card and all other pertinent medical information

MEDICALLY COMPLEX CHILDREN PLAN

Foster children who have moderate to severe ongoing medical issues and have conditions that range from acute to chronic represent a special population. Special placements and services are required to effectively manage and care for these foster children. Currently in place is the Medical Therapeutic Foster Home Services (MTFHS). SCDSS has a Medically Fragile consultant at the state level to work with county and regional staff to identify and obtain appropriate services. Providers are specially recruited and trained to meet the individual needs of the foster child. The goal is to enable the child and his/her family to deal with medical problems in a highly supportive, individualized and flexible placement, assisting the child in returning home or to be placed adoptively.

Foster parents receive specialized training from medical professionals on the illness, medical issues and appropriate methods for working with and caring for the foster child. The foster parent becomes an integral and important part of the treatment team for the child.

SC DHHS has a waiver program specifically for the more acute medically fragile population. The Medically Complex Children's Waiver (MCCW) offers additional support and coordination statewide. A child has to meet Medical Eligibility Criteria, meet Nursing Facility or Intermediate Care Facility for the Intellectually Disabled criteria, be Medicaid eligible and under 18 years of age. Anyone can initiate a referral for the waiver program.

MTFHS services may be offered in three levels of intensity depending on the needs of the child/youth. MTFHS Eligibility Criteria is used to justify the need for treatment services which are necessary in order to diagnose, treat, cure, or improve and preserve health or well-being essential to life. There is a list of 18 different criteria, with three levels of progressive criteria of severity utilized.

In the next five years there will be some areas of enhancement to the existing MTFHS service delivery by development of a consistent array of services and coordination. The Medically Fragile state consultant will be directly involved in case management practices oversight to improve the service delivery between standards and policy within the agency. A MTFHS specific training curriculum will be developed and implemented introducing the policy and procedures for working with the medical fragile population and will set the stage in the beginning for a case worker to succeed. Ongoing training and consultation will be provided from the state consultant to provide extra support for these specialized cases in order to equip case workers with the tools necessary to manage medical complex cases. Case workers specializing in MTFHS in each region would provide more consistent coordination of appropriate services.

The funding for medically complex children does not allow for the billing for a number of services available to severely behaviorally impaired children (i.e., PRTF admission). This creates a situation where children who have both severe medical and severe behavioral needs end up being excluded from some of the specialized medical services and coordination of care which would be available if the added behavioral problems were not present. The goal would be to add the Medical Case Management and dually-trained Therapeutic Foster Homes for this group.

[Example: adolescent with severe seizures or diabetes and severe behavioral problems is unable to leave PRTF because suitable home and management for both simultaneously could not be found.]

BECOMING A TRAUMA-INFORMED AGENCY

Introduction

Each year in the United States millions of children experience some form of traumatic experience. These include physical and/or sexual abuse, living in the terrorizing atmosphere of domestic violence, natural disasters, car accidents, life-threatening medical conditions, painful procedures, and exposure to community violence. All can have traumatic impact on the child and family.

By the time a child reaches the age of eighteen, the probability that any child will have been touched directly by interpersonal or community violence is reported as between a quarter and half of all children. Traumatic experiences can have a devastating impact on the child, altering their physical, emotional, cognitive and social development. In turn, the impact on the child has profound implications for their family, their placement, school success and their community.

Traumatic events in childhood increase risk for a host of social (e.g., teenage pregnancy, adolescent drug abuse, school failure, victimization, anti-social behavior), neuropsychiatric (e.g., post-traumatic stress disorder, dissociative disorders, conduct disorders) and other medical problems (e.g., heart disease, asthma). The deterioration of public education, urban violence and the alarming social disintegration seen in some of our urban and rural communities can be traced back to the escalating cycles of abuse and neglect of our children.

DSS has made a commitment to become a trauma-informed agency. The South Carolina Trauma Practice Initiative will be a collaborative project between the SC Department of Mental Health, the SC Department of Social Services, other local community partners to be determined, Project BEST, and the Program on Adolescent Traumatic Stress (PATS) at the National Crime Victims Research and Treatment Center (NCVC) at the Medical University of South Carolina. Project BEST is a collaborative project between the Dee Norton Lowcountry Children's Center and the NCVC.

The State of South Carolina is committed to developing a comprehensive plan for a coordinated response to childhood trauma. This commitment is to develop and implement a program which can be a national model. The SC Department of Social Services, in collaboration not only with Project BEST at the Medical University of SC, but with the SC Department of Mental Health, the SC Department of Juvenile Justice, and other Partners and Stakeholders has established a set of policies and protocols which guide this initiative. A comprehensive response includes at a minimum, first, a trauma screening and assessment protocol, then the initiatives already begun, and finally, future goals falling within the 5-year planning period.

Generally speaking, when natural disasters are not considered, the greater proportion of children referred for trauma screening are suspected of having been victims of trauma which occurred in their own home. Child victims of trauma who are placed in foster care come almost exclusively from this group. Statistics from Fostering Court Improvement data for FY 2012-2013 indicate that of 47,554 reports of maltreatment in SC, 17,971 investigations were pursued leading to 9569 cases which were "founded" for victims of neglect or abuse. Physical abuse accounted for 3204 of the cases and sexual abuse was confirmed in 483 children. 2126 children entered Foster Care during the 12-month

period. Trauma Protocols were to have been carried out on all 9569 cases, but no precise data is captured in the current data system to document either the number of children screened or the number screened and referred for complete assessments. 23,673 “unfounded” cases were referred to Alternate Response, rather than accepted as Treatment cases. 78 of these children, however, had to later be placed in foster care.(3) At this time no analysis is available for children placed in Foster Care which can show or predict the number of children who required, or might require, intensive treatment modalities, such as Trauma-Focused CBT. Neither is there data showing the number of “complex trauma” cases among the overall numbers. More data would be immensely helpful in planning. The trauma that children experience simply from the fact of being removed from their homes is a confounding variable in assessment and treatment.

The assumption is that the majority of children, after positive trauma screens and assessments, who are then referred for intensive trauma-focused treatment, are among those who have been removed and taken into Foster Care, although again, precise numbers are not available as yet. All of these unanswered questions represent needed further research and will be addressed in proposals suggested for the next 5-year period.

In July of 2007, Project BEST of South Carolina in collaboration with SCDSS began trauma-informed training and providing trauma screening and assessment tools to organizations and individuals that serve children in foster care around the state. Project BEST is a statewide collaborative effort that uses community-based dissemination, training, and implementation methods to increase the capacity of every community in South Carolina to deliver evidence-supported trauma focused mental health treatments to every abused and traumatized child who needs them. Project BEST is funded by the Duke Endowment and coordinated by the Dee Norton Lowcountry Children’s Center in Charleston, SC and the National Crime Victims Research and Treatment Center of the Medical University of South Carolina, also located in Charleston, SC.

CURRENT ACTIVITIES/ INITIATIVES

SCDSS and DMH Trauma Informed Workgroup

The SCDSS and DMH Trauma Informed Workgroup began as a collaborative in September 2012. The collaborative included SCDSS County Directors, DMH Child and Adolescent Family Directors, and the Project Best Co-Director, from the Dee Norton Lowcountry Children’s Center met monthly until the end of calendar year 2013. The purpose of the workgroup was to develop strategies toward improving mental health access and outcomes for children served by the child welfare system. The immediate goal was to develop a plan to ensure that all children and adolescents in the foster care system would be screened and when appropriate assessed and treated for trauma. Additional desired outcomes from our working together were identified:

1. To increase access to mental health treatment for children in the Foster Care System
2. To improve working relationships between the two agencies.
3. To reduce fragmentation of services and supports to families known to both systems through increased coordination and collaboration.
4. To gain an appreciation and understanding of the strengths as well as limitations faced by each agency and to identify ways to bridge the limitations together.
5. To identify local needs as well as resources to help achieve our joint collaborative goals.
6. To determine three long term solutions that could easily be implemented within the next three months to improve outcomes.

7. To identify future training needs to increase both the capacity for trauma informed services and collaboration between the agencies.

Understanding the critical role that collaboration plays in improved outcomes for the children both agencies serve, the workgroup focused on developing a collaborative response protocol between our agencies to ensure that screening, assessment and treatment activities occurred timely and that the relevant information gathered through screening and assessment be shared in support of determining the treatment needs of individual children. The sharing of information also provides needed documentation for DSS case files.

An assessment and treatment protocol process was developed for use between the two agencies and LIPS Managed Care Organization providers known as *The Protocol for Trauma Screening and Assessment for Children Entering Foster Care*. Through this collaborative work group, agencies identified other practice areas needing attention. Initial MH assessments were not being consistently completed within 24 – 48 hours of a child entering care statewide as defined in "The Interagency System for Caring for Emotionally Disturbed Children (ISCEDC) Protocol". This along with other issues around consultations, assessments and information sharing were addressed in the proposed protocol. The Protocol for Trauma Screening and Assessment proposes an initial trauma history by DSS as part of the safety and risk assessment process. All children representing "Found cases" and taken in custody will be referred to the Mental Health Center locally for trauma screening, also utilizing information gathered by the DSS Caseworker at the time the trauma history was taken. For those screening positive on the trauma history, a referral will be made for a comprehensive trauma assessment to determine the impact of trauma and appropriate treatment service needs. The referral for a more complete trauma assessment within 30 days may be made either to the Mental Health Center or to a private certified LIPs provider. If trauma focused services such as Trauma Focused Cognitive Behavioral Therapy are recommended, a qualified clinician will be obtained either through the Mental Health or MCO systems. The proposed assessment and treatment protocol is currently under review by the leadership at SCDSS and SCDMH. While the workgroup is waiting for approval of the protocol, several counties have expressed an interest to pilot these procedures. It is expected that this protocol may become a component of trauma informed practice through the SC Trauma Practice Initiative described below.

SC Trauma Practice Initiative

The South Carolina Trauma Practice Initiative is an example of a public/private partnership designed to translate what we have learned from research about trauma into practice. This Practice Initiative began in 2014 as a collaborative effort between the SC Department of Mental Health, the SC Department of Social Services, Children's Advocacy Centers, other local community partners, Project BEST, and the Program on Adolescent Traumatic Stress (PATS) at the National Crime Victims Research and Treatment Center (NCVC) at the Medical University of South Carolina. Project BEST is a collaborative project between the Dee Norton Lowcountry Children's Center and the NCVC and has been funded by The Duke Endowment

The goals of this Initiative are to use the Community-Based Learning Collaborative (CBLC) dissemination approach developed and implemented by Project BEST to: 1) build strong, working collaborative relationships between DMH clinicians, DSS caseworkers, and other both public and private clinicians and brokers in every county in South Carolina; 2) train DMH therapists and other community therapists to deliver Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) with a high degree of fidelity and competence; 3) train DSS workers and other community brokers in trauma-informed services, including evidence-based interventions, evidence-based treatment planning, case management skills for treatment success; 4) increase the collaboration between community professionals in the identification, treatment planning, treatment delivery and treatment monitoring to completion; and 5) insure that every abused and traumatize child in every county in South Carolina who needs it, receives best practice services and treatment.

Six Community-Based Learning Collaboratives (CBLCs) will be conducted. Each of these CBLC's will include two two-day face-to-face trainings as well as regular consultation over a 10 month period. Bi-weekly consultation for clinical participants will support the use of assessment to inform treatment and fidelity to the intervention model. Monthly consultation to the brokers will support the use of trauma history taking, referring for trauma assessment for those who have a trauma history, the inclusion of TF-CBT in treatment/service plans as indicated and the case management for treatment success. The monthly consultation for the Senior Leaders will focus on overcoming barriers to effective collaboration as well as identifying and overcoming barriers to implementation of an evidence based trauma focused treatment intervention.

Each CBLC includes: 1) DMH clinical supervisors and therapists from 2 to 4 MHCs; 2) an average of 10 community therapists; 3) DSS supervisors and senior caseworkers from the included counties; 4) an average of 5 community brokers of mental health services; and 5) an average of 20 senior leaders from the participating MHC, county DSS agencies, CAC and the community.

The CBLCs have been constructed for geographic proximity so that participants will be participating in learning collaboratively with other professionals from their area. Practically this supports the participants' ability to travel daily to and from learning sessions. In addition this creates networking opportunities, offers face to face knowledge of one another and allows for opportunities to collaborate on developing consensus on actions designed to share the responsibility for outcomes for the traumatized children within their own communities.

In these CBLCs, the plan is for a total of 281 DMH clinicians and 60 other therapists, to be trained to provide TF-CBT; 180 SCDSS brokers will be trained, along with 30 brokers from other community agencies/organizations; and 120 senior leaders will participate, for a total of 671 professionals. Thus far we have had 95 participants in the Spartanburg-Beckman CBLC of which 34 registrants were DSS staff. On May 12-13, 2014, another CBLC was held in the Grand Strand and has 121 registrants, with 33 being DSS employees

The long-term goal of Project BEST is to ensure that all South Carolina children and their families, who are identified as having experienced abuse and resulting trauma, receive appropriate, evidence-supported and trauma-focused mental health screening and assessment and psychosocial treatment services. Project BEST involves teaching clinicians how to deliver evidence supported mental health treatments (ESTs) and enabling brokers of mental health services to identify and refer appropriate children for treatment, incorporate ESTs into their treatment planning, and monitor treatment progress. Project BEST provides the training and ongoing consultation needed to build the knowledge and skills necessary to deliver ESTs and implement evidence-based treatment planning and case management with fidelity. The treatment of choice being implemented by Project BEST is Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). Project BEST has trained South Carolina's Child Advocacy Centers (CAC), individual SCDMH Counselors and a number of private practice individual counselors and clinicians across the state. Brokers from SCDSS and other case management agencies have also been educated in how to obtain appropriate trauma focused services for children and their caregivers.

Workforce Development

Increasing our capacity to provide trauma-informed care and treatment to our children and families and collaborating with other professionals in the identification of these children, in developing treatment plans and in monitoring treatment to completion is vital to achieving successful outcomes. Project BEST will collaborate with SCDSS and

SCDMH to support our transition to a more trauma-informed agency through additional training, practice change and policy revisions are needed to make this transition.

In order to make this transition successful, we are asking that all counties develop an implementation team. This team will include staff demonstrating leadership and a desire to become trauma-informed. At a minimum this team should include 1 person from family preservation/foster care and 1 person from IFCCS. This team will be responsible for ensuring an adequate number of people are signed up for the Project Best Collaborative and other opportunities for trauma-informed education as well as the implementation of concepts learned. Efforts to ensure implementation could include monthly discussion, one-on-one coaching, and/or mentoring colleagues who have difficulties with implementation, etc. The team will also be responsible for evaluating practice to ensure an increase in becoming trauma-informed.

Following implementation of the training and development of full capacity, after a year and each year thereafter there needs to be evaluated. This will require that metrics be identified and collected to assess outcomes to include the costs and effectiveness of the interventions, particularly looking at how successfully therapists were able to engage biological families and Foster Parents in the treatment process and how often therapists were able to adhere to the model in terms of this significant adults involvement and the ability to stick to a weekly schedule of therapy. The clinical pictures of the Foster Children referred need to be reviewed and cases of complex trauma vs. simple trauma compared in terms of participation in and completion of treatment. Lastly, clinical success in terms of reduction of symptoms, stability of placement, returns to family or adoption, and change in psychiatric diagnoses and reduction in need for psychiatric medication or hospitalization need to be reviewed. Of further interest would be therapists' self-reports on whether they felt the utilization of TF-CBT had been successful, and for private therapist whether problems, such as cancelled or failed appointments, reimbursement issues, or difficulties getting approvals for treatment from the MCO, paperwork, and so forth altered the amount of time they would continue to participate in the program. Mental Health Centers would need to report whether or not setting aside dedicated therapists for the program (as many might do) had seemed cost-effective in the end.

- SCDSS is represented on the State Trauma Informed and Workforce Development Committees through the Joint Citizen and Legislative Council on Children to develop a trauma informed workforce throughout the child serving agencies in South Carolina.
 - Statewide core competencies have been developed pending approval by the Council (Draft, attachment 1.)
 - Statewide core competencies have been developed for the workforce development committee that will combine those developed by the trauma-informed committee into training opportunities.
 - Trauma informed training has been made available regionally to SCDSS staff to further knowledge of trauma impact on children and families.
- A trauma informed screening, assessment and treatment draft protocol has been developed by the DSS/DMH Trauma Informed workgroup waiting feedback for potential revisions before implementation. (attached)
- Basic trauma informed perspective with specific tasks has been incorporated into the Guided Supervision training and implemented by supervisors during supervision to ensure that a trauma history is included with the initial safety and risk assessment and referrals are made for trauma impact assessments and treatment where indicated.
- A staff member was trained in the Train and Trainers Child Welfare Trauma Informed Tool Kit developed by the National Child Trauma Stress Network and offered by the Chadwick Center. A trauma informed overview has been developed based on the above and being provided to staff to include a specific emphasis on secondary trauma for staff and first responders.

Up through the current time, 484 professionals have participated in the Project BEST training and 148 are currently rostered to provide Trauma-Focused Cognitive Behavioral Therapy, the majority of who are at the Department of Mental Health (40) or Child Advocacy Centers (53).

Trauma-Informed Initial Assessments (Current).

When a child comes into foster care in the counties, the initial comprehensive medical assessment is completed within 24 hours or no later than five days of entry into care.

- The initial mental health assessment is completed within 24-72 hours of entry into care. This is almost always done at the Community Mental Center in the county where the child currently resides after removal. If the Mental Health Center is unable to provide trauma screening in a timely manner, SCDSS will seek to schedule the screening through a qualified private LIPs provider.
- A BabyNet referral form is completed and forwarded to BabyNet for a screening within two working days of an indicated case of child abuse or neglect for which a child under the age of three years is involved, or upon learning of a suspected developmental delay, or the child is identified as affected by illegal substances or demonstrates withdrawal symptoms resulting from prenatal drug exposure. The child's CFASP is updated as necessary. Service providers are given a copy of the portion of the child's plan that relates to the service they are to provide. BabyNet will screen, assess and evaluate a child referred by DSS to determine if early intervention services are appropriate for that particular child.
- When a report or suspicion of physical or sexual abuse is received by the Department of Social Services, the county office location where the report is received makes a referral to one of the 17 CACs that are dispersed throughout the state for a face-to-face forensic interview and/or medical evaluation. The CACs are child-focused, facility-based programs in which interdisciplinary teams of professionals such as medical and clinical, child protection, victim advocates, and law enforcement professionals make team decisions based on medical assessment of child abuse and neglect. MOUs have been signed between the SCDSS county offices and local CACs to coordinate services for children. All suspect reports regarding non-acute sexual abuse, sexual assault, sexually transmitted diseases in children ages 11 and under, bruises, scalds, burns, fractures, child's exposure to methamphetamine or its production, etc., are referred to CAC for a forensic assessment.

Protocol for Trauma Screening and Assessment for Children Entering Foster Care

Development of the Protocol represents a joint effort by SCDSS, the Department of Mental Health, and Project BEST.

1. "The intent of the Protocol is to immediately address the potential trauma that the child and family members experience at the child's removal." The protocol does not remove any mandatory responsibilities of DMH/DSS but rather, reflect a commitment to enhance coordination, timeliness and services to children and families. This process begins with an initial referral to DMH within one business day of the child entering

care either by telephone or fax. DSS should consult with DMH prior to brokering for a protocol assessment from a private provider.

- DSS will refer the child to DMH within one business day of being taken into care,
- DMH will offer an appointment for the child to be seen within 3 business days of the referral unless there is an urgent need for the child to be assessed immediately.
- DMH will provide verbal consultation to DSS about any imminent safety issues or urgent mental, physical, or psychiatric needs immediately and no later than 24 hours of the protocol assessment. The initial consultation is available for ISCEDC staffing and decision making if a therapeutic level of care is being requested.
- In situations where a DMH assessment cannot meet the established guidelines for timeliness, DSS will make an appointment with a qualified private therapist (from Licensed Independent Practitioners, LIPs) in the community to carry out the evaluation. This referral will be reimbursed retrospectively by the MCO after the child is enrolled.

Referral information available to DMH or the LIPs Provider may include the following (depending on the purpose of the referral - initial consultation, trauma assessment or treatment following the trauma assessment) and information available at the time of referral:

- Contact Information of DSS Caseworkers involved (name, phone number, email address, supervisor's name, phone number and email address)
- Guardian Ad Litem contact information (when assigned)**
- Court orders (when available)* restraining orders and information related to findings on the parents, current and history of drugs, violence, child maltreatment, other treatment related issues included in the court order.
- Trauma history recorded by the SCDSS Caseworker, as soon as available.
- Safety and Risk Assessment information to include Safety Plan and trauma history (when available)*
- Treatment Plans and Placement Plan prepared for court (when available)*
- Parent/Caregiver contact information (name, relationship, address and phone numbers)
- Foster/Resource Parent contact information (name, address, relationship and phone numbers)
- Therapeutic Foster Parent contact information (Company name, parent name, address and phone number along with clinical coordinator)
- DSS Release of Information request
- Any other evaluations or reports relevant to treatment

**As a rule, this information is not available for the initial consultation when the child first enters care but would be available for the comprehensive trauma focused assessment and/or treatment.

2. A Family Team Meeting (FTM) will be convened following the child's removal to address immediate safety and seek safe and appropriate family placement as an alternative to foster care. Ideally, the FTM will occur the next day or at the latest prior to the Probable Cause Hearing.
3. DMH or the LIPs Provider will be invited to attend to participate in the FTM as part of the initial consultation. DMH or private therapist will attend as schedules permit, along with the provider agency facilitating the FTM.
4. If the child remains in care, a trauma history will be completed by DSS within 7 calendar days of the child entering into care and made available for the 7 calendar day Guided Supervision staffing. Those who screen positive will be referred for further assessment and treatment. A copy of the trauma history and additional relevant referral information, if available will be sent to DMH or the selected private provider.

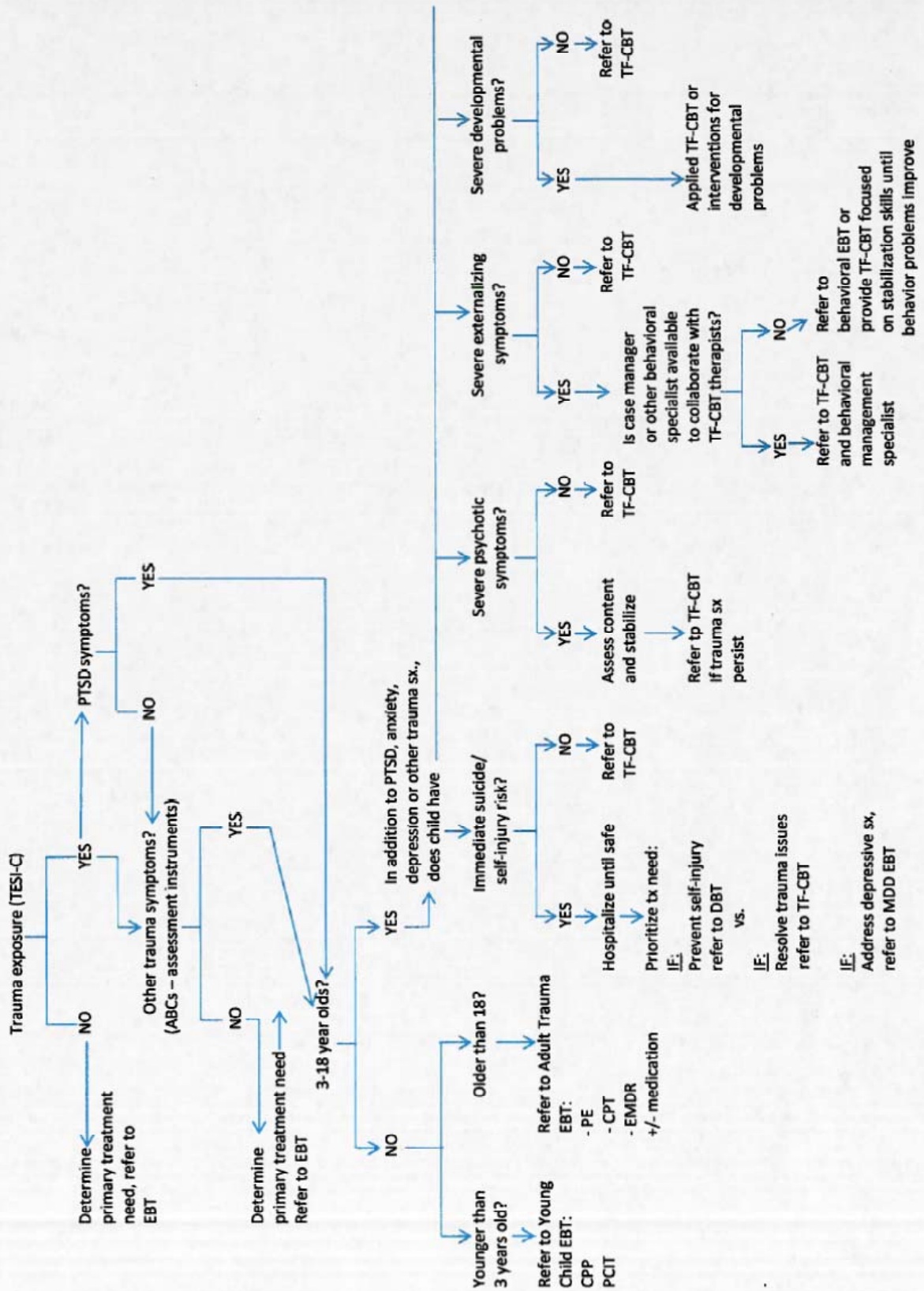
- The determination of the provider will be based on a number of variables, selection through Select Health, the managed care organization for many of the children in foster care, the capacity of the local mental health center to provide trained clinicians in delivering trauma focused evidenced based treatment services and the availability to provide assessment and treatment services in the home as well as availability after work hours and weekends if these are the only times available for parents/caregivers; if the child remains in the same geographic area where the original trauma screening was done and the initial screener is trained to complete the trauma assessment, assigning the complete assessment to the same individual will enhance continuity of care and the reliability of the findings.
5. A referral for a trauma focused comprehensive assessment will be made upon completion of the trauma history, as indicated by the history.
- The initial clinical appointment to complete the trauma-focused assessment will be scheduled within 7 business days of the initial DSS request for the assessment. Recognizing that the assessment may require more than one appointment and considering the additional trauma symptoms that removal from family might have provoked, the findings from the assessment should be completed and made available to DSS before the 30 day staffing.
 - The initial clinical assessment interview will include a face to face diagnostic interview with the child and caregiver. Focus will include reasons for the child being taken into the state's custody, review of the trauma history, indicators of trauma (e.g. nightmares, flashbacks, mood disturbances, fear responses), mental status, safety issues, family history, history of previous treatment, and exploration of treatment needs.
 - Tools to use in assessing the impact of traumatic or potentially traumatic events may include several options.
 - TSCC/TSCC-A
 - TESI (includes parent report*)
 - UCLA PTSD Index for DSM-IV (child/adolescent and parent report*)
 - Parent Trauma Questionnaire (parent report*)
 - Mood and Feelings Questionnaire (child and parent report*)
 - Child Behavior Checklist (parent *, teacher report)
 - Conner's Rating Scale (parent *, teacher report)

*All parent report measures need to be completed by the parent who cared for the child at the time of removal or the DSS caseworker who has thorough knowledge of the child to accurately report information to the interviewer.

- DSS will support a separate family assessment to be conducted within 5 business days.
 - The family assessment will include a face to face diagnostic interview with identified family members to include reasons for the child being taken into the state's custody, review of the trauma history to include additional trauma screening of relevant family members, history of psychological treatment, mental status, safety issues, family history, history of previous treatment, clinical history of the child, completion of the genogram resulting in the formulation of an appropriate treatment plan and early identification of family needs and resources.
- Written documentation of the child and family trauma focused assessment will be provided to DSS within 2 weeks of completing the assessment. The written documentation will include a description of information gathered in the clinical interview, mental status exam, medical, physical, education and psychiatric concerns/needs, the name of and interpretation of any assessment instruments administered, a provisional diagnosis, recommendations to ensure safety and recommendations for treatment, including specific modality of treatment being recommended, e.g., Trauma-Focused Cognitive Behavioral Therapy.
- Assessment information will be used during the DSS 30 day staffing (Guided Supervision) to determine strategies and options for brokering recommended services. If the assessment includes recommendations for treatment, DSS will secure an appropriate provider capable of

delivering the recommended treatment interventions from either the Mental Health Center or a private LIPs provider. The treatment of choice unless otherwise specified due to age or other factors will include trauma focused cognitive behavioral therapy for the child including the caregiver if possible. A decision tree used by Project BEST in choosing from among therapeutic options is included on the next page.

ASSESSMENT ALGORITHM FOR REFERRING TO TF-CBT



- If the local Mental Health Center is chosen as the service provider, MH will provide the following:
 - Assign a therapist within 7 business days of referral
 - The therapist will contact the caregiver and the child within 72 business hours of assignment to schedule clinical services as soon as possible
 - Adhere to best practice clinical standards for evidenced-based treatment services to include frequency of services along with the structure and duration of sessions based on the modality's manual for implementation using recommended assessment tools and progress measures.
 - DMH will complete progress summaries every 90 days from the admission to DMH services providing a written summary of the treatment and progress. If any appointment is missed by a child, family, resource, etc..., DMH will notify the DSS Case Manager that within 24 business hours.
 - DMH therapist will be invited to attend the Family Group Conference/Child Conference and provide an update regarding participation and progress in treatment. This meeting is usually scheduled to occur within the first two months of a child entering care however, it can occur at any time. If DMH is not able to attend, a progress summary reporting strengths, concerns and treatment options will be provided.
 - DMH will work with family/foster family and other identified resources for the child as recommended for services.
 - In the case of a DMH emergency for a child, either the child's MH therapist or MH supervisory personnel will be made available to consult with the case manager, foster parents, hospital staff, etc. regarding best care and recommendations for the child.
 - When a child's placement is in jeopardy, DSS will consult with the DMH therapist. DMH therapist or DMH supervisory personnel will be made available to consult with case manager, foster parents, residential staff placement, etc.
 - DMH will notify case manager of any staff changes of the therapist assigned to child/family. Once services are complete, DMH will provide a written summary of the treatment to include progress by each participant, and any further recommendations. This should include pre-post outcomes, results of screening tools, objective measures, matrix measurements, etc... relevant in meeting treatment fidelity measures.
6. DSS further agrees to:
- Immediately contact DMH when a crisis occurs, when placement is in jeopardy of disruption or a child is moved. If a child has moved, the contact information of new provider will be provided (name, address and phone number) to coordinate continuity of mental health services.
 - Contact the CAF Director with any treatment concerns that have not resolved between DSS and DMH staff. Does CAF need to be spelled out?
 - Call CAF Director if any questions or issues arise as the Directors can assist in problem solving or provide assistance to accessing needed services.
 - DSS agrees to provide training/information:
 - On the Child Welfare Trauma-Informed Tool Kit to county DSS staff. Local DMH offices will be invited to participate in the training.
 - On the trauma history and structured interview

- On the DMH referral process to include information needed to complete comprehensive assessment to include an overview of the safety and risk assessment tools, best practice and outcome expectations.

* Note: This process will be individualized with consideration given to the child's cognitive, medical, psychological and developmental functioning.

YOUTH IN FOSTER CARE TURNING 18 OR MOVING TO INDEPENDENT LIVING

If youth is age eighteen or older, the court no longer has jurisdiction, so if the youth needs continued placement arrangements, he or she can sign SCDSS-30136 Agreement for Continued Placement of Persons 18 to 21 years of age, provided:

- The youth age 18 requests to remain in placement through the agency
 - The youth entered care prior to the youth's 18th birthday
 - The youth has no other alternative permanent plan option available and is not yet ready for emancipation.
- The youth is enrolled in a GED program, or is a full-time student in a postsecondary educational setting or in vocational preparation training or youth has developmental, medical or psychiatric issues.

When the youth leaves care, he or she will have originals of their birth certificate, social security card, and Medicaid card (youth in foster care on their eighteenth birthday can automatically qualify for Medicaid coverage until age twenty-one under Transitional Medicaid).

The SCDSS Human Services Policy and Procedures Manual Section 832 and 832.01.01 (Revision Number: 10-05, Effective Date: 09/24/2010) states that the youth's Transition Plan must include information about healthcare power of attorney and healthcare proxy along with the necessary documents for the youth to execute the power of attorney/proxy if he/she chooses to do so. When the youth leaves care they are provided their Medicaid card and the Education and Health Passport, any relevant medical information and a resource book on Medicaid and health providers.

Note: Special discharge planning is provided for those teens that have developmental, medical and/or psychiatric conditions which will significantly prevent them from living independently. Staffing with Family Independence, Adult Services, relatives and other agencies involved with the teen is coordinated to develop an ongoing supportive network for the teen. Additionally, the agency is evaluating the recent program instructions under the new Health Care Act.

Interagency Transition Meetings for our 17 to 21 year old special needs population should take place around their 17th birthday and again at age 20 to insure that the services are in place and add any services as they age out of DSS. At the planning meeting the client and family should expect representatives from all serving agencies who have or who may be potentially involved with the client. Those at the table beside the client and family are

Department of Disabilities and Special Needs, Department of Juvenile Justice, Department of Mental Health, Independent Living, case manager, supervisor, clinical consultant and private provider. Vocational Rehabilitation and the school district are invited when indicated. The client and family need to have input at this meeting.

The discussion presented includes, but is not limited to:

- 1.) The service coordinator needs to coordinate with their clinical consultant any new psychological or evaluation that the client might need.
- 2.) Are the needs and strengths of the client understood by the group? What Interagency services are currently in place or need to be put in place at this time?
- 3.) Have community resources been identified and used?
- 4.) Presumption of the least restrictive services and maintaining the client in the community?
- 5.) Service decisions are substantially determined by an interagency process based on client driven needs.
- 6.) Use of specific mental health setting (e.g., intensive after school services, therapeutic day camp, supervised employment) with contracted staff.
- 7.) Has a contract been signed with the client? Are all personal responsibilities and expectations understood by the client and family?
- 8.) Health care plans are explained to the client to enable them in making a good choice of a plan to meet their health care needs.
- 9.) Finally, proposed treatment involves a plan, and subsequent demonstrated efforts to implement plan, with active participation of parents, guardians and other responsible adults.

The purpose of this team is to assist the client with a seamless as possible transition into adulthood with services in place and supportive adults in his or her life as they move forward once leaving the Department of Social Services.

MEDICATION OVERSIGHT: PSYCHOTROPIC MEDICATION

Background

Over the last decade, there has been an exponential increase in the use of psychotropic medications prescribed to children with emotional and behavioral disorders. There is a paucity of convincing scientific knowledge to suggest all psychotropic medication utilization in children is effective and has a positive risk-benefit profile. The use of these medications in the foster care population is significantly higher than a similar socioeconomic non-foster care Medicaid beneficiary group. Specific medication classes (e.g. antipsychotics) are no exception and have been found to be used as many as nine times more frequently than a control group of Medicaid members not in foster care in different studies (4). Congregate care settings are also known to use medications four times more frequently than in less restrictive community placements (5). Foster children are clearly a vulnerable population with unique treatment needs as a result of early childhood trauma. There is significant overlap between reactions to trauma and symptoms of other mental health disorders (e.g. ADHD or Bipolar Disorder). Investigation is ongoing regarding the appropriateness of medication use based on diagnosis, medication dosage, and the age of foster children receiving medication.

The passage of the Fostering Connections to Success and Increasing Adoptions Act (FCSIAA) of 2008 required State and Tribal agencies to develop a plan for ongoing oversight and coordination of healthcare services for children in foster care (6). Furthermore, the Child and Family Services Improvement and Innovation Act strengthened FCSIAA by requiring that the plan include an outline of protocols for the appropriate use and monitoring of psychotropic medications. It also requires that the healthcare oversight and coordination plan outline how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from his/her home.

South Carolina Profile

To date there have been two studies assessing prescriptions for psychotropic medications for children in Foster Care in South Carolina. Both of these studies have looked at children in foster care served either by Regular Foster Care services or by Intensive Foster Care and Clinical Services (IFCCS). IFCCS regional offices serve children who have been screened and determined to have significant mental health treatment needs. The larger second study also compared children in Foster Care to non-foster care children in the state who are on Medicaid.

Because of the bundled rate payment to Psychiatric Residential Treatment Facilities (PRTFs), children in those facilities were not included in either study as no individual medication data was being reported to the Medicaid Agency. This situation will change with enhanced encounter reporting in the future.

In 2011, recognizing the need for a protocol for monitoring of psychotropic medication of children in foster care, SCDSS acknowledged the lack any existing protocol to accomplish this task for children in the foster care system. To assist in developing such a protocol, DSS in-house surveyed the use of psychotropic medications in a small controlled sample population which would allow the State to begin the process as a pilot in one area, and then develop resources as it expanded the process across the State for all children in foster care. The State determined that the resources within the IFCCS and the specialized caseload staff for this population would contribute to greater success in development of a system that would enable the agency to monitor and consent to the use of all psychotropic medications.

In 2011, data was collected on the smaller group of children in IFCCS and regular Foster Care in a 10-county region of the State. The data showed the following data over a 6-month period of time:

- 73% of all youth in Intensive Foster Care (IFCCS) were on a psychotropic medication
28% of youth in Regular Foster Care were on a psychotropic medication
- 32% of youth in IFCCS were prescribed an antipsychotic drug
4% of youth in Regular Foster Care received an antipsychotic
- 49% of youth in IFCCS were prescribed a stimulant drug
30% of youth in Regular Foster Care had been prescribed a stimulant
- 30% of youth in IFCCS received a prescription for an antidepressant
7% of youth in Regular Foster Care had a prescription for an antidepressant

An additional finding was that the number of children on three or more different psychotropic medications (does not double count different forms of the same medication, and does not count medication prescribed to treat side-effects or to treat enuresis) was 30% among the IFCCS population. The number of children under 6 years old in that same population on psychotropic medications was 3 (out of 10 total children in the sample); all were on a single medication for ADHD.

There is an emphasis on placements utilizing the "least restrictive environment" which can effectively address the child's needs in as little time in out-of-home placement as possible. This approach has shown a 60% decrease in the average daily census to around 90 for SC Foster Children in Psychiatric Residential Treatment Facilities over the last several years. This appears to have been accomplished both at the point of screening for placement, but also as PRTFs have worked to reduce lengths of stay and also position themselves to carry out brief (30-60-90 day) admissions for extended diagnostic assessments and stabilization. This decrease in use of higher levels of care (a national trend) represents an area of concern for future outcome-based studies, in order to refine the criteria used in decision-making.

For planning purposes, it was important to know how many of these children were scattered throughout the communities in Therapeutic Foster Care or Pre-Adoptive Homes rather than residential treatment facilities. The survey showed 169 out of 258 children surveyed were in foster homes or with pre-adoptive families, and the remainder was in congregate care. Again, for planning purposes, it was important to know how many of these children in community placements were receiving their medications through community mental health clinics under DMH. Using a smaller random sample, that figure was 63%.

The second study (7), carried out by the University of South Carolina Institute for Families in Society was more comprehensive and also looked at Medicaid members who were not in DSS custody, but only made comparisons within the group of all children receiving prescriptions for psychotropic medications, using pharmacy data as its source. Among the findings were those describing the psychiatric diagnoses on children receiving at least one antipsychotic medication prescription during the year showed?

- Among children in Intensive Care, 84% of those receiving a prescription for an antipsychotic had a diagnosis of ADHD; a slightly lower percentage of those in Regular Foster Care receiving an antipsychotic prescription showed 79% carried a diagnosis of ADHD; more surprising was that 66% of Medicaid members not in Foster Care who received similar prescriptions also had an ADHD diagnosis.
- A diagnosis of one of the Disruptive Behavior Disorders-type diagnoses was a diagnosis in 78% of the children in IFCCS receiving an antipsychotic prescription and 50% of those in Regular Foster Care, with 37% in the non-Foster Care population.
- Mood disorder diagnoses also were highly represented in children receiving antipsychotic prescriptions: 74% (IFCCS), 59% (RFC), and 46% (non-FC).

It is clear from the numbers that children in all groups were being given multiple diagnoses. Among the children not in Foster Care who received an antipsychotic, the number of diagnoses was 1.64 per child, but in Regular Foster Care it was 2.7 per child and in Intensive Foster Care it rose to 3.3 diagnoses per child.

The percentages of these children who were seen by psychiatrists or at a Mental Health Center was 66% for Medicaid members not in Foster Care, 86% for those in Regular Foster Care, and 89% for those children in Intensive Foster Care.

Looking at multi-class prescriptions (multi-class poly-pharmacy) showed ADHD medications prescribed over the

study period when the child also received an antidepressant was 27%; also receiving an antipsychotic was 14%; also receiving an anticonvulsant 8%; and receiving ADHD medication plus an antidepressant plus an antipsychotic was 8%.

These findings generally suggest that diagnostic specificity is difficult among all Medicaid member children, but certainly less clear among Foster Children, with the clear possibility that antipsychotics are being widely prescribed where the primary diagnosis is ADHD. It also appears that a third of children not in Foster Care were being prescribed antipsychotic without psychiatric consultation; the percentage for foster children receiving these medications from their Primary Care Physician (PCP) was roughly half of that. These numbers are not precise because of (1) PRTFs are not reimbursed separately for medications, and (2) there is a mix of congregate care—lower levels than PRTF—utilizing DMH Psychiatrists as opposed to private contracted Psychiatrists.

CURRENT ACTIVITIES / INITIATIVES

Development of DSS Clinical Team

The SCDSS has regionally-based licensed clinical staff that work together as a team (the clinical team) to provide 24/7 support to DSS staff members that make healthcare decisions for foster children. The clinical team consists of regional clinical specialists (RCS), a lead clinical specialist (LCS) and a medical director. Over the past 18 months, the clinical team has expanded from 4.5 FTE positions to 11 FTE positions with the addition of multiple RCS, an LCS, and a medical director.

RCS staff is spread throughout the state's IFCCS offices and the LCS and medical director are based at the state office. Four of the five regions have two RCS positions. One smaller region has one RCS position. All members of the clinical team are licensed with the South Carolina Department of Labor, Licensing and Regulation; all RCS and LCS staff is master's level clinicians and the medical director is a board-certified child and adolescent psychiatrist.

RCS staff is available to all DSS staff to assist with health care decisions made on behalf of foster children from the time of removal until the child leaves foster care through reunification, adoption, or emancipation. This includes, but is not limited to, informed consent decisions for medications or medical procedures, placement in a therapeutic foster home, congregate care placement, or hospital discharge planning. The LCS and medical director provide clinical supervision to the RCS on a regular basis. The LCS and medical director are also the points of contact for internal and external stakeholders for policy development and health care coordination initiatives with state agency and community partners.

In addition to day-to-day regional clinical responsibilities, the clinical team also manages the psychotropic medication Informed Consent process, monitors PRTF and other congregate care placements, and works closely with DHHS to obtain pharmacy claims information to identify prescribing trends that may require additional follow-up.

A rotating on-call system has been implemented to allow 24/7 clinical team availability. The clinical team has access to a HIPAA-compliant secure fax line increasing the ability of the team and outside providers to share documents. On-line video conferencing ability is available as well as a standing conference line. All psychiatric residential treatment centers (PRTFs) in SC now participate in a mixed retro- and prospective Informed Consent process for psychotropic medications. These medications are tracked on a spreadsheet which will soon be linked to a portal in the CAPSS (SACWIS) system. A monthly dashboard provides information on the prevalence of psychotropic usage in PRTFs including breakdowns according to class, number of medications, and length of stay in PRTF. Basic clinical knowledge training is in development with a university partner with input from the clinical team.

SCDSS will roll the Informed Consent process out to all levels of care within the next five years. As this process expands, additional clinical positions will be indicated. Clinical team members will assist in staff training to enhance knowledge of basic clinical issues (when to ask questions, what questions to ask, etc.)

Psychotropic Medication Consent and Monitoring:

Conversations on developing a plan for monitoring psychotropic medication for children in Foster Care began in April 2011. In October 2011, development was begun on a specific pilot project to provide oversight regarding these medications specifically for children and youth in the highest levels of care, initially only in six psychiatric residential treatment facilities (PRTFs) located in SCDSS Region 3, a ten-county area centered in Charleston.

The 2011 Pilot Project was designed to train staff and to test policies and methodologies to oversee the use of psychotropic medications. From the outset, it was accepted that children in foster care were often coming from home situations characterized by trauma, in some cases where they were physically or sexually abused, and that these children were more likely to show serious psychiatric problems that might require medication. The guiding philosophy has to be, however, to "Think Trauma First" and clearly understand how the child's collective traumas have played a role in the current symptoms, such that evidenced-based trauma-informed therapies are primary in treatment planning. At the same time, the use of psychotropic medications, when indicated, needs to be more closely monitored. It was also accepted that children in the highest level of care are likely among the most severe from a psychiatric point of view, both as regard to diagnosis and disruptiveness.

The Pilot Project became operational in February 2012. The project captured 15% of the IFCCS clients in that region. The facilities involved had all expressed an interest in being a part of the pilot and agreed to help with the training of SCDSS-IFCCS staff on the uses for various psychotropic medications and their side-effects.

Training for case managers and SCDSS Clinical Staff:

Because of the small number of children in foster care studied in the pilot project, the training was limited to

the case managers for those children. An initial trial of a training package, completed before the pilot started was made mandatory for all Caseworkers and Supervisors in the pilot region. Follow-up and monitoring of psychotropic medications was initially seen as a responsibility of the case manager, but the Service Coordinator (SC) or Caseworker (CW) was instructed to request consultation from Regional Clinical Coordinators, or the consulting psychiatrist based on a protocol for the types, doses, and multiplicity of medications being prescribed.

The initial aim in evaluating the use of any medication was to assess whether there was a clear “positive response,” an “incomplete positive response,” “no benefit observed,” or a “negative response.” The assumption was that a “negative response” would result in discontinuing the medication. “No benefit observed” or an “incomplete positive response” could result in a request to increase the dose. Insofar as the provider makes these judgments, they may form the basis for requesting a higher dose, a different medication, or using multiple medications. The prescribing physician was required to also document the effectiveness of any medication prescribed and make notes available to the SC/CW, who was to share them with the parents. In Treatment Team meetings in residential settings, the SC/CW or their representative attended; the parent was invited as well as the Guardian ad litem (GAL) and other involved parties.

The second responsibility was to be certain that the medication is not harming the patient, and that side-effects, if present, were either tolerable related to the documented benefits, or were treatable. In some instances, the case manager needed to ask for lab studies, weights, or medical reports, and ask for help from the Clinical Team in interpreting the data. The issue of whether a child or adolescent on multiple medications (not always psychiatric) might be taking medications which affect one another in a negative manner was a concern, but questions needed to be brought to the attention of the agency medical staff. Likewise, the intent was that these issues should be well-documented in the medical record, and the record available to the SCDSS workers, parent, and GAL.

While it seemed clear that a case manager-driven model for Informed Consent and monitoring was in the long run not a good model, it took two years to build the Clinical Team within SCDSS, including hiring of a Medical Director, to the point where all these functions could be handed over completely to that Team and expansion to all the PRTFs throughout the state could be accomplished.

A fairly significant finding, though, from the Pilot Project was that even in a flawed system, the fact that an informed consent process existed seemed to produce more conservative approaches to medication, and the pharmacy chief for three facilities reported an overall decrease in medication prescriptions. There were some patients with significant orders for prescribe-as-needed medications for agitation or aggression. It is not clear if that use was unchanged or had been altered one way or the other.

By the latter part of 2013, the Prospective Consent for psychotropic medications in PRTFs had been expanded to all PRTFs in the state.

The current procedures utilizing the Clinical Team to review requests prospectively to prescribe

psychotropic medications in the PRTFs in South Carolina are fully prospective, except in the cases of emergencies or the need for prn medications. A *Notification Regarding Psychotropic Medication* form is completed by the treated provider for each of the following circumstances:

- o New medication initiation
- o Medication discontinuation
- o Titration of a medication outside the dosage range previously agreed upon
- o Continuation of a medication started 6+ months ago
- o Emergency medication administration
- o Continuation of medications at time of admission to a congregate care facility

A notification form is not necessary prior to making a medication decision for emergency medication use or continuing medications at time of admission to a congregate care facility.

General elements of the PRTF Medication consent procedures:

- When the child's parent's rights have not been terminated, efforts are made to keep the parent or guardian informed regarding use of medication, cognizant of the family's religious or cultural concerns. In addition, as a child ages, the adolescent will be given an increasing role in consent for use of medication, always taking into account the child's cognitive development and level of understanding. Youth over the age of 16, unless unable to adequately do so, will consent to their own medications. The Clinical Coordinator will arrange a meeting with the child and case manager or service coordinator should a child consent to a medication regimen that SCDSS feels may be inappropriate.
- If there are disagreements between the provider and agency/parent/youth regarding a prescribed medication, a physician-to-physician consultation will be scheduled. Following this consultation, the medication request in question is approved, modified, or denied.
- Once the notification form has been completed, and modified if necessary, the Clinical Coordinator communicates with the provider, guardian, case manager or service coordinator, and records the medication and associated health information.
- The primary method of Informed Consent (IC) communication is via the Secured Fax (SFax) system. SFax is a HIPAA-compliant web-based system. Providers send the IC forms (DSS 1214) to the SFax. When a SFax is received, all members of the clinical team receive email notification of the fax. A clinical team member from the child's region reviews the request consulting with the Medical Director as needed. The requests are approved, denied, or placed in pending status. Prior to denying or pending a request, contact is made with the physician requesting the change to further explore the request. The IC form is returned to the prescriber, placement, case worker, and Lead Clinical specialist. The Lead Clinical Specialist maintains an Excel spreadsheet tracking all informed consent requests received. A portal into CAPSS has been developed to transfer this information into. When the portal goes live, informed consent requests will be directly entered in

the portal. The clinical team members are able to access the SFax system remotely via an android cell phone app.

- When a child enters a PRTF, a DSS Form 1214 is completed by the facility noting all medications the child is on at the time of placement noting a projected dosage range. These medications are “grandfathered” in to prevent disruption in medication. For any further changes in medication – increases/decreases beyond the projected or previously approved maximum dosage levels, new medications, discontinuing medications and emergent medications a new DSS 1214 is to be completed and sent to the clinical team via the SFax.
- Turnaround time for a response by the clinical team is 48 hours. Decreases and discontinuations may be initiated prior to return of the IC form. Increases or additions are not to begin until the IC form is returned to the facility.

GOALS / OBJECTIVES

Finalize design and expand the Psychotropic Medication Oversight Plan to all children in foster care.

The State will work towards a uniform, streamlined medication consent process for children in foster care that is transparent and engages prescribing healthcare professionals, insurers, and SCDSS. SCDSS will continue working with the Department of Mental Health (SCDMH) and SCDHHS regarding this process. SCDSS is in favor of a mixed prospective-retrospective consent model, allowing SCDSS to review and consent to medication prior to administration and review aggregate prescribing trends on a monthly basis. SCDMH is in favor of a primarily retrospective consent model. Both options have advantages and disadvantages. One of the major concerns under discussion is the administrative and financial burden associated with a prospective approach. Officials from both agencies are optimistic about arriving at an agreement regarding informed consent for the administration of medication. Simultaneously, SCDSS has engaged with private managed care companies on this issue, and has received generally favorable reception to the idea of a prospective consent model.

In the interim, SCDMH has a group of administrative staff, including agency medical directors, who have agreed to regular meetings to discuss medical and mental healthcare treatment issues that impact children in foster care.

SCDSS will oversee the use of psychotropic medication using a three-tiered network of the agency's clinical staff, with accompanying policies, procedures, and training to ensure caseworkers and healthcare professionals recognize the State's goals, its requirements, and have access to SCDSS clinical staff. SCDSS clinical staff will serve as trainers to caseworkers and caregivers, as consultants and consent givers for medical and mental healthcare, and as analysts reviewing aggregate and individual level data to identify trends and improve care.

Policy and training will alert caseworkers and healthcare professionals to criteria created by SCDSS that differentiates clinical scenarios where consultation can be requested if desired from those where consultation and/or consent from SCDSS clinical staff is required.

Clinical staff will provide the first line of consultation for all children in foster care, as well as conducting retrospective reviews by auditing records for all children in foster care to ensure appropriate healthcare services are being provided. Clinical staff will work with both SCDSS caseworkers and healthcare professionals to coordinate all care, and will provide consent to care within a defined scope of criteria. SCDSS has developed a rotating call system for clinical staff, ensuring that clinical staff is always available to provide consultation for clinical emergencies.

The primary push from this point forward is to develop an approach to consent and review of psychotropic medication for the bulk of Foster Children who are not in PRTF placements. On average this would equate to 3000+ children as opposed to approximately 90 as an average daily census in PRTFs.

While prospective medication review has been successful (not without resistance) in the PRTFs, input from community psychiatrists and pediatricians has shown universal opposition to prospective reviews in the community, with the general belief that this would bog down patient appointments and interfere with running their practice. There is concession, however, that PCPs would like more consultation, particularly around the use of certain drugs (i.e., antipsychotics), or more immediate available help from a psychiatrist on certain diagnoses or symptoms (i.e., suicidal thinking) where the pediatrician or Family Practitioner is uncomfortable or where emergency hospitalization might be needed.

Utilizing the alternate model of Retrospective Medical Team Review, such as used in Texas (8) and other states, appears to present a more workable solution for out-patient settings. The timeliness in providing telephonic or electronic support is a critical variable within the small time frame of the out-patient appointment and the Agency does have the capacity to handle this. An out-patient Prospective Medical Review, such as differing ones in Connecticut and Tennessee, would seem to require a medical infrastructure not available in South Carolina. In addition, review of those models showed problems occurring in other states, including the difficulty in getting the medical community to come on board with prospective review. In South Carolina, the major current provider, SCDMH, has reacted favorably to the proposal for retrospective reviews. At the current time, South Carolina has a very limited pool of private practice Child Psychiatrists not contracted to congregate care facilities open to taking new Medicaid patients. As the State has moved into a managed care model, using a single MCO, greater resources may emerge through enrollments of Child Psychiatrists in the private community, but to what degree is unclear. To the extent that the Community Mental Health Centers remain key providers, the proposed model appears to be the best choice.

Retrospective Review Model

Utilizing Retrospective Review, the following guidelines are proposed as triggers indicating the need to review psychotropic medication(s) prescribed to any individual foster child; any of the following suggests the need for additional review of a youth's clinical status:

- A. Primary triggers, which can be determined with information immediately available from the pharmacy billing patterns:
- Four (4) or more psychotropic medications prescribed concomitantly (side effect medications are not included in this count).
 - Prescribing of two (2) or more psychotropic medications from the same class (e.g., two or more antidepressants, two or more antipsychotics, etc.). *The prescription of a long-acting stimulant and an immediate release stimulant of the same chemical entity (e.g., methylphenidate) does not constitute concomitant prescribing.*
 - The psychotropic medication dose exceeds the usual recommended doses (FDA and/or literature based maximum dosages).
- B. Secondary triggers which can be determined by adding a review of information available in CAPSS (DSS electronic record); assumes proposed changes in CAPSS which expand historical data and updated diagnoses:
- Use of a medication with no FDA indication for the disorder or symptoms being treated before attempting a trial of a medication with an FDA indication.
 - Psychotropic polypharmacy (2 or more medications) for a given mental disorder or symptom is prescribed before exhausting monotherapeutic options. *Cross tapers should be completed in a timely fashion, typically not more than 4 weeks.*
 - Antipsychotic medications prescribed to children less than age 6, or any psychotropic medication prescribed to a child less than age 5.
- C. Tertiary triggers which can only be uncovered utilizing additional information beyond Pharmacy data and data from CAPSS, often necessitating direct communication with the Provider:
- Absence of a thorough assessment for the DSM-5 diagnosis in the youth's medical record.
 - Frequent changes of psychotropic medications without a clear rationale.
 - Prescribing by a primary care provider who has not documented previous specialty training for a diagnosis other than the following (unless recommended by a psychiatrist consultant):
 1. Attention Deficit Hyperactive Disorder (ADHD)
 2. Uncomplicated anxiety disorders
 3. Uncomplicated depression
 - Use of PRN or emergency medications more than twice a day for three or more consecutive days.
 - Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every 6 months.

Barriers to implementation of a Retrospective Review model include the following:

- The general need for a uniform approach with all out-patient prescribers, but a recognition that different classes of physicians (DMH Mental Health Center Psychiatrists, Psychiatrists in private practice, Pediatricians, or Family Medicine physicians) might need somewhat different triggers for review.
- Conflicting Legislative and Policy Considerations: The SC Code for Social Services, Chapter

8-83:5. In general, there are several paragraphs in the South Carolina Code that have bearing on the issue of consent to mental health treatment. In the Mental Health Code (Section 44-22-140), it states that "(B) Competent patients may not receive treatment or medication in the absence of their express informed consent in writing [except] (1) During an emergency. . . (2) as permitted under applicable law for a person committed. . ." Section 20-7-290 states that "A minor who has reached his or her sixteenth birthday can consent to healthcare without input from a parent or guardian." But Section 20-7-107 reads: "In South Carolina a 'child' is defined as an individual under the age of eighteen." Section 44-24-20 states that a child over age sixteen "voluntarily admitted" must apply themselves for admission, but this section is written in the context of hospitalization, rather than outpatient care. The rights of a competent child over age 16 to apply for and accept or refuse out-patient care or medication is not specifically addressed. This represents a conundrum for SCDSS as other legislation and policy gives DSS responsibility to make medical decisions for children in custody until age 18. DMH would generally need to follow the age 16 consent law.

The Department of Mental Health has already enunciated general guidelines they would accept:

- They understand the requirements placed on DSS and would support the concept in any way that they can without placing unrealistic burdens on agency doctors, nurses, and clinicians.
- They support a retrospective review process (as opposed to a Prospective Review) by DSS as a way for SCDSS to meet its parental role.
- DSS needs to be able to access prescription information electronically, without needing to contact the Physician or clinic directly; DMH would supply information to the adult accompanying the child at the time of the encounter just as they would for any other child and parent.
- The adult bringing the child to the appointment must have the authority to provide informed consent for medication to be prescribed.

It would seem that these stipulations probably reflect the views of other practitioners, as well. There are some technical capabilities not reflected in bullet #3. DMH is initiating a program to send FAX letters to PCPs after they see a patient, relating the pertinent details of the visit. It would seem that copies of these letters could go to the DSS Clinical Team if there is an easy way to flag Foster Children in the DMH data base system to capture the out-going FAX. A problem, obviously, is that children are entering and leaving Foster Care on a routine basis, but their status at DMH or with other professionals may be unchanged; therefore this is a challenge in managing data across agencies. From the other direction, the Clinical Team or even the Caseworker at DSS may quite frequently be unaware of a physician appointment having been made by the Foster Parent and kept, except later through encounter data from the MCO.

In order to manage a Retrospective Review covering 3000+ Foster Children utilizing the above criteria for review, DSS would need to build capacity by adding additional medical staff, preferably a RNs (or possibly a Pharmacy Consultant), who could work as a team when Regional Clinical staff detect reviewable cases. The Medical Director / Child Psychiatrist would be available as further back-up. An alternative consideration would be to out-source the medication reviews, but this would suffer from the paucity of clinical data being readily available that an in-house review team would have access to.

A plan exists in its formative stages to develop through the University of South Carolina contract the three videos mentions earlier targeted at Physicians and their staff, DSS staff, and Foster Parent, along with natural family or pre-adoptive families. These would provide education on medications and doses acceptable for use with Foster Children, the Retrospective Review oversight model through DSS, and the processes of Informed Consent permissible under

SC Law and DSS policy. It is suggested that this be developed in a format, such as Moodle which can allow interactive learning. Additional trainings within or from the Clinical Team will be the responsibility of the Medical Director, and other medical personnel when they come on board.

Other Goals Include:

- Data system initiatives to streamline and increase captured information relating to informed consent and medication use. Thus far in FY2013, SCDSS has engaged in interagency dialogue between SCDSS, the Department of Health and Human Services (DHHS), and the Office of Research and Statistics (ORS) to develop a memorandum of agreement to enable data sharing regarding psychotropic medication usage by foster children, as well as utilization of other mental health services and hospital utilization. Dialogue will continue with ORS, DHHS, and the MCO to allow "real time" access to medication claims data and mental health services utilization data for individual children in foster care.
- Development of auditing protocols to compare healthcare provider and State records. In FY2013 the SCDSS Medical Director has audited medical records relating to psychiatric/mental healthcare for children in foster care on an as needed basis to staff individual cases with healthcare providers and caseworkers. The SCDSS Medical Director has developed a set of criteria for caseworkers to clarify when consultation with and review of health records by SCDSS clinical staff is desirable.
- A dedicated Clinical Research arm of the Agency to be developed to guide decision-making specific to medication / program review tied to outcomes. This could be coordinated with the SC Department of Health and Human Services, perhaps contracted through the University of South Carolina Institute for Families in Society, Division of Policy and research on Medicaid and Medicare.
- The relative unavailability of private practice Child Psychiatrists accepting SC Medicaid or enrolling in the MCO and serving Foster Children, beyond those Child Psychiatrists employed by medical schools or contracting with PRTFs, requires a different approach to the goal of providing psychiatric consultation to PCPs serving Foster Children. Several suggestions have been brought forward for consideration: (1) SCDSS hiring additional psychiatric staff to provide consultation; this has the limitation that these Psychiatrists might not necessarily have ready access to a hospital bed in an emergency; (2) Developing a consultation model in concert with the Department of Mental Health, possibly using telemedicine with live back-up as needed in an emergency from the local Mental Health Clinic.
- Expanded training initiatives for direct, supervisory, and clinical staff. SCDSS worked with MUSC to develop and execute a contract to provide training initiatives to direct, supervisory, and clinical staff. Once this contract ended, the SCDSS Medical Director began conducting on-the-job training in April 2013 for IFCCS staff, affiliated service coordinators, and case managers as needed. Training includes information on symptoms and illnesses, treatment modalities, and availability of treatment services.

OVERSIGHT OF NON-PSYCHOTROPIC MEDICATION

At the current time SCDSS has no overall policy regarding medical review, prior authorization, or clinical oversight

regarding the prescription of non-psychotropic medications to Foster Children. There are limitations in the Consent Law to the extent that the child's family of origin must consent to medical care not defined as "ordinary," but the relationship between prescribing practice and law or policy is not spelled out. The best-practices goal for SCDSS is to utilize a proposed addition of RNs or APRNs to the Clinical Team to begin addressing this issue in-house, but to work with the MCO, CHIPRA, and the SC American Academy of Pediatrics to establish a best-practices model which can be employed and inform policy with established protocol and procedures. This addition of a RN or APRN medical professional could also work closely with the Medically Complex children's program and provide a liaison between that program and the Clinical Team.

Current Practice:

Upon Intake the worker determines the status of ongoing health issues (i.e. diabetes), confers with the child, caregiver and others as appropriate to determine what medications (if any) the child is prescribed and if the child is taking medication as prescribed for a physical condition. The worker follows up as directed by the medical provider. In Foster Care the Foster parent and congregate care facilities are responsible for medication monitoring, documenting, and administration. Foster parent and direct care staff are required to be trained in medication administration.

Congregate Care facilities are required to have a medication policy which: requires prescribed medication to be stored in a secure, double-locked location. It specifies the approach for administering medication and the documentation requirements including medication logs, frequency of medication reviews, as well as the process for training on informed consent if applicable. The policy requires medication logs to show the dates and times medications were dispensed and include the initials of the staff member who dispensed them. It requires adherence to any future drug policies to be developed by the SCDSS as to requirements for permissions to use certain drugs or certain dose levels; and requires an effort to utilize medications which would be available to the child following discharge through Medicaid / MCO formularies.

Providers are required to provide staff with an overview of the use of medications commonly used for children (if applicable, with a focus on psychiatric medications) and side effects that, when displayed by the child, would require the provider to notify the SCDSS case manager. In a discharge summary, congregate care providers are required, if appropriate, to include the arrangement of supervision of medication by a licensed professional and a referral to appropriate therapeutic services through the child's PCP.

Goals:

Improving oversight of non-psychiatric medication prescriptions would likely require additional personnel with the SCDSS Clinical Team, possibly a part-time contractual relationship with a Pediatrician or Pediatric Clinic and an RN on staff.

DATA MANAGEMENT GOALS

Medical information will be updated and appropriately shared, including development and use of electronic health records:

South Carolina is committed to maintaining accurate medical records for children in foster care. The CAPSS, South Carolina's SACWIS system, provides a platform for incorporation of case file information in an electronic format. Currently, a child's current medical status as well as some historical information (e.g. immunization records, medical and mental health diagnoses, and medical providers) can be recorded in CAPSS. The capability to store more comprehensive medical information in CAPSS is being developed.

- The child and family treatment plans are currently completed and maintained in the CAPSS system. A recently revised child plan will allow CAPSS to capture more medical and mental health information – both current and historical. Old plans are maintained in the system when new plans are developed, thus providing a historical record. The medical and education passport contains important information that will be captured in CAPSS once additional data entry fields are added. Maintaining accurate information on the passport can be challenging given that it requires collaborative relationships between DSS staff and providers. Work is in progress to allow CAPSS to track completion of the initial comprehensive medical assessment, including screening for trauma and mental health symptoms, and compliance with EPSDT schedules. In order for CAPSS to be fully functional as an electronic record for DSS there also needs to be a way to add or appendix graphic data (school reports, psychological test data, medical tests, etc.) to the file.
- In addition to internal agency efforts, South Carolina has developed the South Carolina Health Information Exchange (SCHIEEx) system, an electronic clearing house which will allow EHRs stored on different platforms by different Providers to “talk” to each other and transfer information across the health care grid. This program, begun several years ago is currently still at the early stages of training and statewide rollout. While SCDSS is a SCHIEEx member, provider enrollment has been slower than expected (Physicians describe problems as “cost, difficulty with access,” and “what’s in it for me?”) and information available on SCHIEEx is minimal at present. For SCHIEEx to be fully functional for SCDSS and other state agencies as well, a method for transfer of information from SCHIEEx to the agency EMR (CAPSS for SCDSS) will need to be implemented.
- SCDSS is currently working to expand its ability to maintain results of laboratory and other diagnostic studies in CAPSS. The ability to review and maintain mental health records from the Department of Mental Health (DMH) in CAPSS is also in progress. In addition to reviewing clinical records, there is the possibility that DMH could expand its pilot project that notifies PCPs when psychotropic medications are prescribed. Expansion of this pilot to include SC DSS would improve the ability to monitor use of psychotropic medications by foster children.
- In addition to potentially receiving notification from DMH when foster children have received psychotropic medications, monthly pharmacy claim reports for all foster children have been developed with data beginning 1/1/14. Reliability testing for sample runs is currently under way to ensure all children receiving prescription medications are captured and those leaving Foster Care are deleted. Pharmacy data for children in PRTF placements is managed through the Informed Consent process.
- The intent to capture the Education and Health Passport into CAPSS would enable rapid updating and would allow a duplicate to be printed as the originals given to Foster Parents seem to get lost easily.

OTHER SPECIAL GROUPS OF FOSTER CHILDREN

HIV and Foster Care

When children come into the agency's custody from situations that placed them at risk of HIV (i.e., children born to parents already known to be HIV positive, those who have been subjected to sexual abuse those who have engaged in intravenous drug use, etc.), the agency will:

- Set up a supervisory staffing upon learning that a child entering, or already in care, is at risk for HIV. The purpose of the staffing is to:
 - Endorse the use of universal precautions for all children in care
 - Determine the necessary steps to take in order to obtain a medical diagnosis that confirms or rules out a diagnosis of HIV and to obtain this evaluation in a manner that is least traumatic for the child
 - Plan how to share the information with the engaged placement provider, in assisting the department and the child with the continuing supportive placement
 - Plan how much information to share with the age-appropriate child
- Upon receiving information that the child is HIV positive or HIV active:
 - Endorse the use of universal precautions for all children in care
 - Solicit all medical recommendations necessary to plan for the future medical treatment and home care precautions needed by the child
 - Consult with foster care program staff and/or Office of General Counsel on proceeding with advising the child's parents
 - Plan how much should be arranged for the child, providers and parents

Children Exposed to the Manufacture of Methamphetamines

For children exposed to the manufacture of methamphetamines, SCDSS utilizes the procedures from the South Carolina Drug-Endangered Children Protocol (SCDEC Protocol) which was developed to help coordinate services among different agencies in South Carolina. After law enforcement has taken emergency protective custody of a child, the CPS and/or foster care worker must remain with the child through the medical assessment until they are appropriately placed. A child may have been exposed to hazardous chemicals.

- The CPS and/or FC staff also interview the parents and other adults (at the site) to collect health history information about the child. The information is documented on: Medical Information Form 4 and Medication for Children Form 5
- CPS and/or FC worker takes the child to a medical provider for an immediate care assessment as soon as possible but no later than 6 hours of a child's removal from the scene of a methamphetamines lab. CPS and/or FC worker arranges for completion of a mental health screening to be conducted between 24 and 48 hours of the child's entry into foster care
- The CPS and/or FC worker provides the Exam Information Form 6 to the physician examining the child. Within 30 days of the child's baseline medical assessment, the worker arranges for a mental

health evaluation. This evaluation is conducted by a mental health professional, psychologist, or a licensed therapist.

- The CPS and/or FC worker arranges for completion of a 30 day medical follow-up visit (from the child's baseline medical assessment) to identify any latent symptoms and to provide appropriate intervention.

Pregnant Youth in Foster Care

The foster care policy manual outlines specific actions for the caseworker and supervisors in the management of a pregnant youth in care (Chapter 8, Section 833). Additionally, there are other case management guidance and policy direction for teen parents in foster care (Chapter 8, 833.01 Ongoing Services for Teen Parent in Foster Care and 832.01.01 Transition Planning prior to emancipation).

The biological mother has a right to consent to medical treatment even if the mother is a minor. Court intervention may be necessary if the mother refuses to consent for medical services for illnesses or injuries that are considered life threatening to the infant/child or the infant/child could suffer permanent harm without the services. This is a drastic step and is evaluated on a case-by-case basis.

When a youth in foster care is pregnant, the foster care worker coordinates a referral to a physician or to the local health department to confirm the pregnancy. The foster care worker also refers, supports, and assists the pregnant youth in obtaining prenatal services and related counseling on issues surrounding pregnancy as identified by the physician and as outlined on the Child and Family Assessment, Services and Plan (CFASP). The foster care worker will assist the biological mother in accessing resources available to help support the mother and child's well-being. While services may vary by area, some general resources that are considered include prenatal checkups, children's health clinics, EPSDT for children on Medicaid, immunizations, Women, Infant and Children (WIC) food supplement program, health education, screening for and treatment of sexually transmitted diseases, and evaluation and treatment of children with physical handicaps or chronic illness.

Potential additional services include services from Family Independence staff, Medicaid, transportation for medical appointments for Medicaid-eligible clients, Child Support Enforcement, adoptions and general case management.

If the pregnant youth indicates a desire to seek an abortion, and if the youth is under age 17 and cannot obtain the requisite consent, SCDSS refer youth to an area adoption staff. SCDSS cannot consent to an abortion, but can assist the youth with applying to Family Court for consent for such medical treatment without parental consent (SC Statute 44-41-32). As Medicaid is the primary health insurer for children in foster care, SCDSS will consult with Medicaid staff regarding any abortion procedure coverage.

ATTACHMENT 1

The Core Competencies of Trauma-Informed Care for Agencies and Organizations in South Carolina that Serve Children, Adolescents, and Their Families

Core competencies are the knowledge, attitudes, and skills that all employees and volunteers of agencies and organizations in SC must have in order to respond appropriately and effectively to traumatized children, adolescents, and their families and in order to maintain a trauma-informed environment.

Please note that the following content specific to core competencies is based primarily on “Trauma Informed & Developmentally Sensitive Services for Children: Core Competencies for Effective Practice” which was developed by the Health Federation of Philadelphia in The Multiplying Connections Initiative. We have been granted their consent to use their content.

The core competencies will define standards, relevant to trauma, in the following areas:

- knowledge
- values and attitudes
- communication
- practice
- organizations and systems
- communities

Agencies and organizations that serve children, adolescents, and families in South Carolina are comprised of employees and volunteers who represent multiple disciplines, levels of education, and work roles. As a result, **not every employee will be expected to have expertise in every core competency. Each agency and organization will identify, from the competencies described below, both the specific competencies and levels of proficiency which are essential to each job title within that agency or organization.** These competencies address all job functions (support staff, direct services, agency leadership, and policy development).

KNOWLEDGE

Core knowledge needed about trauma and trauma-informed practice in order to provide trauma-informed care to children, adolescents, and their families

Employees and volunteers of agencies and organizations that serve children, adolescents, and families in South Carolina will be able to:

1. Identify and describe signs, symptoms, impacts, and outcomes of trauma in children, adolescents, and adults.
2. Understand how trauma impacts childhood and adolescent development.
3. Explain how behaviors, including those which appear to be “problems” or symptoms, may actually be trauma-related coping skills that children and adolescents use to protect themselves and survive.
4. Explain the effects that trauma can have on the relationship between child and caregiver.
5. Describe the multi-generational nature of trauma.
6. Define re-traumatization, identify ways that children, adolescents, and their families can be re-traumatized or triggered during interaction with the agency / organization, and explain measures taken to minimize this outcome.
7. Describe local resources for trauma-specific treatment for children, adolescents, and their families.
8. Define trauma-informed care and trauma-specific services, know the characteristics of a trauma-informed agency / organization, and be familiar with evidence-based treatment models.

VALUES & ATTITUDES

Core values and attitudes needed to provide trauma-informed care to children, adolescents, and their families

Employees and volunteers of agencies and organizations that serve children, adolescents, and families in South Carolina will be able to:

1. Believe that it is appropriate and essential, for anyone who is involved in providing services to children, adolescents, and their families, to provide trauma-informed care.
2. Recognize that involving children, adolescents, parents, and caregivers as partners in the treatment and recovery process maximizes the potential for healing.
3. Examine personal beliefs about trauma and personal experiences of trauma and understand the impacts these have on interactions with clients, colleagues, supervisors, the agency, and other organizations.

4. View childhood trauma as a significant, complex, and often preventable public health problem with broad-ranging effects on children, adolescents, and adults but from which, with proper resources and support, people can recover.
5. Believe that all services should respect culture, race, ethnicity, gender, age, sexual orientation, and exceptionalities.

COMMUNICATION

Communication skills needed to provide effective trauma-informed care to children, adolescents, and their families

Employees and volunteers of agencies and organizations that serve children, adolescents, and families in South Carolina will be able to:

1. Develop an interpersonal style with clients and with colleagues that is honest, trustworthy, engaging, direct, flexible, reflective, culturally competent, developmentally appropriate, and uses no labels which are derogatory or would pathologize.
2. Communicate and collaborate with children, adolescents, families, professionals, and community partners to establish supportive relationships for healing and growth.
3. Accurately perceive, assess, and express emotions and model non-violent ways of communicating emotions so that a safe environment is maintained for all others and for self.

PRACTICE

Core skills and abilities needed to practice trauma-informed care with children, adolescents, and their families

Employees and volunteers of agencies and organizations that serve children, adolescents, and families in South Carolina will be able to:

1. Facilitate trauma-informed collaborative relationships - with children, adolescents, parents, caregivers, colleagues, and community partners - which demonstrate care, respect, cultural competence, developmental sensitivity, strengths-based approaches,

maximum safety for all, and opportunities for child, adolescent, and caregiver choice and control.

2. Provide trauma screening for all children and adolescents. Provide an evidence-based trauma assessment for all children and adolescents who screen positive for trauma and volunteer to be assessed for trauma.
3. Demonstrate sensitivity to children's and adolescents' parents and caregivers who may have unaddressed trauma issues which can impair their ability to help their children and adolescents.
4. Make and facilitate referrals to trauma-informed and trauma-specific treatment services for children, adolescents, and their families when needed.
5. Demonstrate the ability to teach children, adolescents, and their parents and caregivers evidence-based techniques that help traumatized children and adolescents, such as relaxation and self-soothing.
6. Create environments that are safe, comfortable, and welcoming to all children, adolescents, families, employees, and volunteers.
7. Educate parents and caregivers about risk factors and protective factors associated with trauma and healthy childhood development and assist them with developing the strategies and the tools to strengthen development.
8. Assist parents and caregivers of traumatized children and adolescents to recognize and address any prior unresolved personal trauma and any secondary trauma which develops while supporting their children and adolescents.
9. Educate and support all staff and volunteers about the need to recognize and address any prior unresolved personal trauma as well as any secondary trauma which develops while working with traumatized children, adolescents, and their families.
10. Educate and support all staff about how they may be negatively affected by regular exposure to traumatized clients and their trauma histories and situations.

ORGANIZATIONS & SYSTEMS

Competencies in organizational management, policy change, and system change needed to create and sustain a trauma-informed agency / organization for children, adolescents, and their families

1. Make changes in agency / organization policies, procedures, structures, and protocols which will directly support trauma-informed care and services.
2. Institute trauma-informed policies and services that respect culture, race, ethnicity, gender, age, sexual orientation, and exceptionalities.
3. Teach and train employees at all levels (administration, management, supervisory, direct care, and support) about core elements necessary for trauma-informed agencies / organizations and practices.
4. Involve children, adolescents, their families, other systems and practitioners, and the community in the process of becoming a trauma-informed agency / organization.

5. Establish environments that support all staff and volunteers, that ensure the safety of all clients, staff, and volunteers, and that are customized to meet each child's, adolescent's, and family's needs.
6. Identify and describe effective models of trauma-informed care.
7. Advocate with local, state, and federal policy makers for the development of funding streams and policies that support and foster a trauma-informed service system for all children, adolescents, and their families.

COMMUNITIES

Competencies in working with communities to reduce risk factors and increase protective factors associated with trauma

1. Educate and inform community residents, leaders, groups, and coalitions about childhood trauma, including its causes and effects in individuals and the resources available for recovery.
2. Create and maintain collaborative efforts between community stakeholders to ensure that all children, adolescents, and their families receive trauma-informed care.

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