2013

Psychotropic Medication Guidelines for Children and Adolescents in Colorado's Child Welfare System

Solutions for Coordinated Care

Colorado Department of Health Care Policy and Financing
and Colorado Department of Human Services
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INTRODUCTION

The Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351), required state agencies to develop a plan for ongoing oversight and coordination of health care services for children in foster care. Subsequent to this act, the Child and Family Services Improvement and Innovation Act (P.L. 112-34) amended the law by adding requirements specifying that the plan must include an outline of protocols for the appropriate use and monitoring of psychotropic medications.

The Colorado Department of Human Services (CDHS) and the Department of Health Care Policy and Financing (HCPF) joined together, along with many stakeholders from across the community, to form the Psychotropic Medications Steering Committee (the Committee). The Committee was charged with developing the following recommended guidelines for the state of Colorado.

The vision of the Committee: To ensure the appropriate use of psychotropic medications for Colorado's children and youth in out-of-home care and to integrate medications into comprehensive physical and behavioral health care.

"Several recent national reports have called attention to the issue of psychotropic prescribing in terms of misuse and overuse and similar problems exist in Colorado. As state agencies, we are committed to improving the health of children in foster care and ensuring safe, appropriate, and effective prescribing. Attached is a joint report and guidelines for promoting health and guiding the use of psychotropic medications in the child welfare system from the Department of Health Care Policy and Financing and the Department of Human Services. State Medicaid and behavioral health agencies play a significant role in providing access to quality physical and behavioral health services for children in the child welfare system. Therefore, it is essential that we collaborate to improve care.

We created a special committee of advisors and experts to help guide psychotropic medication prescribing in Colorado who created this report. The Committee included child psychiatrists, pediatricians, family medicine providers, pharmacists, social workers, and family advocates from both the private sector and the state.

This report's purpose is to outline guidance to ensure that children in foster care receive high-quality, coordinated medical services, including appropriate medication, even as their placements change. While medications can be an important component of treatment, strengthened oversight of psychotropic medication use is necessary in order to responsibly and effectively attend to the clinical needs of children.

We expect these guidelines will be regularly reviewed to keep up with new research and evidence based practice. We look forward to working collaboratively in the future.

Thank you for your commitment and dedication to the children and adolescents of Colorado."

Sincerely,

Judy Zerzan, MD, MPH
Chief Medical Officer/Clinical Services Office Director

Julie Krow, MA, LPC
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NATIONAL DATA

Children who come to the attention of the child welfare system have disproportionally high rates of social-emotional, behavioral, and mental health challenges.[1]

- Twenty-three percent of children age 17 and under who have experienced maltreatment have behavior problems requiring clinical intervention.
- Clinical-level behavior problems are almost three times as common among this population as among the general population.
- Among children who enter foster care, approximately one third scored in the clinical range for behavior problems on the Child Behavior Checklist.
- Thirty-five percent of children age 17 and under who have experienced maltreatment demonstrate clinical-level problems with social skills – more than twice the rate of the general population.
- Children in foster care are more likely to have a mental health diagnosis than other children.
- In a study of foster youth between the ages of 14 and 17, sixty-three percent met the criteria for at least one mental health diagnosis at some point in their life.[2]

Psychotropic medications are often prescribed to treat these challenging behaviors and mental health issues. While necessary in some cases, numerous studies have demonstrated that the rates of psychotropic medication prescriptions are disproportionately high among children in foster care. A 2008 study of children in foster care taking psychotropic medication found 21.3 percent are receiving mono-therapy (one class of psychotropic medication), 41.3 percent are taking three or more classes of psychotropic medications, 15.4 percent are taking medication from four or more classes, and 2.1 percent are taking five or more classes of psychotropic drugs.[3]

COLORADO DATA

A 2011 study assessing the use of psychotropic medications by children and adolescents in Colorado's State Medicaid program found some notable trends. *(Please see Appendix A-Colorado AP 11-27-12.)* Although Colorado had a lower percentage of children and adolescents in foster care using psychotropic medications than the eight comparison states, those in foster care in Colorado were three to six times more likely to be prescribed psychotropic medications than Colorado children and adolescents not in foster care. Children and adolescents in Colorado's foster care system were also above the nine-state median for the use of four or more mental health drugs, with 24.3 percent in 2011.

[1] The *National Survey of Child and Adolescent Well-Being* (NSCAW)
[2] White, CR; Havalchak, A; Jackson, L; O'Brien, K; & Pecora, PJ. (2007). Mental Health, Ethnicity, Sexuality, and Spirituality among Youth in Foster Care: Findings from The Casey Field Office Mental Health Study. Casey Family Programs.
[3] Zito, JM; et al., (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics*. 121(1): e157.

[4] Jensen, P.S., Bhatara, V.S., Vitiello, B., Hoagwood, K., Feil, M., & Burke, L.B. (1999). Psychoactive Medication Prescribing Practices for U.S. Children: Gaps Between Research and Clinical Practice. Journal of the American Academy of Child & Adolescent Psychiatry, 38(5), 557-565.
[5] Wethington, H.R., Hahn, R.A., Fuqua-Whitley, D.S., Sipe, T.A., Crosby, A.E., Johnson, R.L., Liberman, A.M., Mos´cicki, E., Price, L.N., Tuma, F.K., Kalra, G., Chattopadhyay, S.K, & Task Force on Community Preventive Services. (2008). The Effectiveness of Interventions to Reduce Psychological Harm from Traumatic Events Among Children and Adolescents: A Systematic Review. *American Journal of Preventative Medicine*, 35(3), 287–313.

SAFEGUARDS

While many children in foster care have mental health challenges requiring intervention which may include the appropriate use of psychopharmacological treatments as part of a comprehensive treatment approach, research on the safe and appropriate pediatric use of psychotropic medications lags behind prescribing trends.[4] There is even less evidence of the effectiveness of pharmacologic interventions for the treatment of trauma-related symptoms in children. For these reasons, protocols and safeguards need to be put in place.[5]

The Committee is recommending the following safeguards be put in place:

Within Colorado Medicaid, the following situations will be subject to prior authorization or Drug Utilization Review intervention:

1. Clients taking three or more psychotropic medications;

2. Clients taking three or more medications in the same psychotropic class at the same time or within nine months;

3. Clients under age five who are prescribed antipsychotic agents;

4. Clients taking antipsychotic agents with no diagnosis of psychosis, bipolar disorder, schizophrenia, or autism;

5. Clients that are prescribed psychotropic agents at doses that exceed their published recommended daily maximum dose.

It should be noted, these requirements and oversight refer only to medications prescribed for children which are payable under Colorado Medicaid. Prescription coverage policies through other plans may or may not have such policies in place.

These situations may require consult with a call line, Behavioral Health Organization (BHO) specialist, or primary care provider (PCP), to assist with the development of a treatment plan.

For additional information on Colorado Medicaid drug coverage policies, please visit the following links to download policy documents:

Preferred Drug List - http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609
<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609>
Appendix P (prior authorization policies)
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132

Additionally, the Committee recommends HCPF, Colorado's state Medicaid agency, perform annual data analysis, identifying prescribers practicing outside of accepted norms with regard to psychotropic medications for children and adolescents. HCPF would then send letters to these providers, informing them that they appear to be practicing outside of accepted norms. This letter would not be punitive, but instead would seek to understand the prescriber's practice, their population type, and any additional input the prescriber might have. A link would be provided for the prescriber to respond to an electronic survey, helping to inform the Committee about the prescriber's practice. The letter would also inquire as to what types of technical assistance may be useful to the prescriber, as well as further recommendations the Committee can provide to HCPF and CDHS.

COMMUNICATION and COORDINATED CARE

Children and adolescents in the care of the local departments of human/social services offer special challenges to the physical, oral, and behavioral health care providers who care for them.

- In State Fiscal Year (SFY) 2011, Colorado received 80,094 referrals, continuing a trend of growth over the past five years. Referrals opened to investigations (i.e., assessments) along with open involvements (i.e., cases) declined. Consistent with the Division of Child Welfare's value of keeping children in the least restrictive setting, the majority of children in open involvement were served in their own homes (71.7 percent).

- In SFY 2011, of the 39,403 children in open involvements, 11,153 were placed in an OOH [out-of-home] setting (28.3 percent of overall involvements).[6]

Many of these children are in care with incomplete medical records and without consistent primary care, a focal point of care, or a medical home overseeing their health and wellbeing. These children represent a vulnerable population with a high rate of behavioral health issues among them. The issue of health and health care for children in the child welfare system is serious. Statistics show that during SFY 2009-10:

- Seventy-four percent of the Medicaid eligible children in foster care had at least one well child visit in comparison to the eighty-seven percent of the eligible children not in the foster care system.

- Sixty-one percent of the Medicaid eligible children in foster care had used dental services at least once. This compares to sixty-three percent of the eligible children not in the foster care system.

- Seventy-one percent of Medicaid eligible children in foster care utilized general pharmacy services at least once. This compares to about sixty-six percent of Medicaid children not in the foster care system who used general pharmacy services at least once.

[6] Powell, C., Smith, C., Madura, B., McCaw, S., Johnson, K., Sushinsky, J. 2011 Annual Evaluation Report, CDHS, Division of Child Welfare

Medical Homes and the Accountable Care Collaborative

Given this information, these guidelines focus on the urgent need for a medical home for the children in the child welfare system. A medical home focuses on the importance of preventative care as well as the importance of appropriate and timely screening for behavioral health concerns.

The American Academy of Pediatrics (AAP) recommends:

"Ideally, at a minimum such reassessments should occur monthly for the first six months of age, every two months for ages six to twelve months, every three months for ages one to two years, every six months for ages two through adolescence, and at times of significant changes in placement (foster home transfers, approaching reunification). These periodicity recommendations, although not backed by evidence-based data, are considered by this committee to be the minimal number of preventive health care encounters required to closely monitor these children. Depending on the stability of the placement and changes in the child's status, additional visits may be indicated. ***Any child prescribed psychotropic medication must be closely monitored by the prescribing [provider] for potential adverse effects.*** (emphasis added)

At each health visit, the pediatrician should attempt to assess the child's developmental, educational, and emotional status. These assessments may be based on structured interviews with the foster parents and caseworker, the results of standardized tests of development, or a review of the child's school progress. All children with identified problems should be promptly evaluated and treated as clinically indicated."

Additional material regarding periodicity information for children in the child welfare system can be found at: http://www2.aap.org/fostercare/policystatements.html.

Children and adolescents in the child welfare system should receive the screening and well child visits as outlined by the AAP. These visits are important to assure that problems are found early and treated as medically appropriate.

Children under the age of five years who are subjects of a substantiated report of abuse or neglect must be referred to the appropriate state or local agency for developmental screening within sixty days after the abuse or neglect has been substantiated. (CCR Vol 7, 7.202.52 (K)).

Colorado is working on providing Medicaid clients with a medical home. The Accountable Care Collaborative (ACC) is a Colorado Medicaid program designed to improve clients' health outcomes through a coordinated, client-centered system which holds providers accountable for health outcomes.

In Colorado, there are seven Regional Care Collaborative Organizations (RCCOs) which provide:

- Medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time, and in the right setting.

- Care coordination among providers and with other services such as behavioral health, long-term supports and services.
- Provider support such as assistance with care coordination, referrals, clinical performance, and practice improvement and redesign.
- Primary Care Medical Providers (PCMPs) are affiliated with a RCCO and act as "medical homes" for clients. As a medical home, the PCMP will coordinate and manage a client's health needs across specialties and along the continuum of care.

Everyone has a mandate to serve the child and there is shared responsibility between the Accountable Care Collaborative (ACC), the Behavioral Health Organization (BHO), the prescriber, and caseworker. The Committee has developed Fact Sheets, to assist these different systems in understanding the needs and services provided by each entity. Child welfare caseworkers need to understand how the ACC can assist in the care of the children and youth they serve and providers need to understand the special needs of the children and youth in the child welfare population. Please see Appendix B for these Fact Sheets. Additionally, information on the ACC is being added to the Child Welfare Training Academy.

Telemedicine

The Committee is also making a recommendation for the increased use of telemedicine in Colorado. Telemedicine is a benefit of Colorado Medicaid and one that can be useful for assessment and treatment for children in rural areas or without access to a needed provider type. The increased access and availability of telemedicine can provide additional consultation, so that providers have the ability for increased monitoring of children and youth on psychotropic medications. Additionally, older youth often prefer telemedicine.

Telemedicine is a way of giving services to Medicaid clients who live a significant distance away from providers they need to see. Telemedicine involves two providers: an "originating provider" and a "distant provider." The provider where the client is located is the "originating provider" and the provider in another location is the "distant provider." Providers must have special equipment to provide telemedicine services. Telemedicine does not mean visits by telephone or fax. All Medicaid clients can receive services through the use of telemedicine, regardless of where they live. Services can only be received at providers' offices that have the special equipment.

Telemedicine services are provided "live" by audio-video communications between two providers. The distant provider is a consultant to the originating provider. Sometimes the distant provider may be the only provider involved in the visit, such as with mental health sessions. Providers such as doctors, nurse practitioners, and behavioral health providers can provide services if they have the special equipment. Telemedicine gives the client access to providers including specialists. Telemedicine is not to take the place of seeing a provider in person when one is available.

Telemedicine is also useful for peer review, peers support and education.

Record transfers between providers

Another barrier in Colorado's child welfare system identified by the Committee is the difficulty providers experience when requesting records. To break down this barrier, the Committee is recommending provider education on how to access services and records. One piece of that education will be to ensure that providers are aware of programs that already exist, such as Colorado Regional Health Information Organization (CORHIO). CORHIO is a public-private partnership that is tasked with the secure implementation of health information exchange (HIE). CORHIO is designated by the State of Colorado to facilitate HIE. CORHIO works closely with and among communities across Colorado to develop and implement secure systems and processes for sharing clinical information. CORHIO collaborates with all health care stakeholders including physicians, hospitals, clinics, behavioral health, public health, long-term care, laboratories, imaging centers, health plans and patients. For more information, please see: http://www.corhio.org/

Tracking psychotropic medication taken by children and youth while they are in foster care is another obstacle. Currently, it is not a mandatory field in the State's Statewide Automated Child Welfare Information System (SACWIS), and therefore, the information is often missing or inaccurate. The Committee is recommending a task group be formed to determine the best course of action to improve the tracking of psychotropic medications. This task group would make recommendations as to who can or should be responsible for entry of medication, i.e. the caseworker, or whether providers can be given access to input information. Tracking this information will provide the ability to accurately identify children/youth on high doses of, or multiple psychotropic medications; identify prescribers who may be outliers; provide a history of psychotropic medications to current providers to mitigate the repetition of children/youth being prescribed medications that have been unsuccessful or have caused negative reactions; and track the progress of the appropriate use of psychotropic medications for children and youth in foster care.

Due to the difficulty of data sharing between HCPF and CDHS, the Committee also recommends exploring options of automating this process. The Committee will monitor work being done through the Interoperability Innovation Grant, to determine if there is an opportunity to combine efforts. Specifically, the Committee would also like to investigate how CDHS can work with HCPF's Statewide Data and Analytics Contractor (SDAC).

Transitioning Youth

Youth who are transitioning from foster care to adulthood are finding it especially difficult to obtain or transfer their mental health records, as well as obtain new or transfer prescriptions. Due to these struggles, the Committee will be looking closely at the work that is being finalized by the Colorado Youth and Children Information Sharing System (CCYIS), particularly the release of information forms developed by CCYIS. The Committee believes that these new forms will be helpful to emancipating youth and can be added as part of the process youth go through with their independent living plans.

The Committee also recommends education for providers regarding transitioning youth. The work between the provider and the youth can be done with a "tool box" that would facilitate this transition process and what needs to be done in relation to integrating their mental and physical health needs.

Recommended Guidelines for a Psychopharmacology Assessment

The baseline of an assessment of a child or adolescent prior to initiating psychopharmacological treatment is complex. It must involve the evaluation of a myriad of biological, psychological, and social variables. The actual purpose of the assessment is multifaceted and includes:

1) The establishment of a therapeutic relationship with the patient and parent/guardian.
2) The formulation and establishment of a working diagnosis.
3) The identification of target symptoms.
4) The development of a comprehensive treatment plan.

It is important to note that co-morbid medical and psychiatric disorders are often present in children and adolescents who require care. All children should have a thorough health evaluation and identification of acute medical conditions prior to the administration of psychotropic medications or when a change of medication occurs. In some cases, medical problems mimic and/or occur co-morbidly with psychiatric disorders. In those cases, the identification of target symptoms is most critical. When pharmacologic intervention is identified as part of the treatment plan, consideration such as diagnostic medical evaluations, drug-drug interactions, poly-pharmacy, treatment compliance, informed consent, and the safe storage and administration of medications become key.

The administration of psychotropic medication should involve appropriate education of the patient, bio parent, guardian, foster parent or other caregiver and caseworker. This should be followed by adequate trial and careful monitoring by the prescribing practitioner, along with treatment by other providers. It is essential that providers be informed and make prescribing decisions based on **all** medication currently being taken by a child, including non-psychopharmacological medications, be communicated to all parties. An adequate trial refers to an appropriate dose of the medication being given over a reasonable period of time needed to obtain efficacy; however, the practitioner must be ever mindful of the possible adverse reactions, which might necessitate a careful discontinuation of the medication. Regular and frequent follow up with the patient, caseworkers, and foster parent is important in enhancing compliance, providing ongoing psycho-education about side effects and medical monitoring of therapeutic effects of the medication, as well as assessing effectiveness of the medication intervention.

The assessment of the medication trial is facilitated by the initial identification of target symptoms and the regular evaluation of those target symptoms. Target symptoms are identified

during the initial intake through caregiver reports, history, and child/adolescent self-report. Assessment measures and norm-referenced symptom checklists can often be helpful in obtaining information about baseline functioning. Ongoing monitoring is critical to medication management. Re-administering assessment measures, gathering information about behaviors from caregivers and professionals working with the child/adolescent, obtaining child/adolescent self-reports, and monitoring of side effects at routine intervals are key components of medication management.

Secondly, the consideration of inter-current life events, particularly to children and adolescents, is also essential in assessing the benefits of medication. The start of school, the change in living situations, physical illness, parental functioning and participation, issues of grief and loss, trauma history, a birthday, etc., can all impact function and can confound the evaluation of medication trials. Thirdly, compliance may need to be investigated through pharmacy records of medication administration in order to clearly assess the efficacy of a medication trial. Once an informed decision is made about a particular medication, changes in the treatment plan may be necessary including changes in medication regime, adjustment in non-pharmacologic treatment strategies, and re-evaluation of the diagnosis.

In children and adolescents, re-evaluation of the working diagnosis is useful not only when there is a lack of treatment response, but also in other situations. By nature, children and adolescents are developing and changing during their treatment. Longitudinal information may become available, revealing temporal patterns of functioning that may alter diagnosis. The successful treatment of one disorder may then expose an underlying co-morbid disorder that requires treatment. Ultimately, the resolution of a disorder of the ineffectiveness of a medication requires medically supervised discontinuation of medications. Because of withdrawal or discontinuation effects may arise and confound the clinical picture, close monitoring is vital to sort out the illness from medication effects. Poly-pharmacy can be avoided or minimized if these issues are considered. Additionally, it is important to note that there is often symptom overlap among common childhood disorders (e.g., post-traumatic stress disorder and attention deficit/hyperactivity disorder). Treating providers should make differential diagnoses based upon diagnostic interviewing, assessments, and review of history when considering psychotropic treatment.

Expectations of face-to-face or phone follow up between the patient and the prescribing provider should occur a week or two after starting the medication. The next visit should occur at one month, then at least quarterly with the prescribing provider, if possible. Information should be shared between PCP and behavioral health provider by direct communication as possible. This would change as dictated by the medication. If the child misses any appointments related to medication management, the case manager should be contacted immediately.

This missed appointment reporting is not meant to create more work, but to assist with communication to assure the placement stays in place. These expectations should also alleviate the need for emergent script renewals without a return visit.

It is also recommended when children or youth leave a foster home, residential care, or a juvenile detention facility, that discharge planning includes a follow-up appointment, which is made BEFORE discharge and enough medications are prescribed to cover the time until the appointment.

It should also be noted for those children and youth age 20 and under and on Medicaid, Health Care Policy and Financing, under the EPSDT Program, does allow for a second opinion. Should the case worker feel this is needed, a second opinion can be obtained without a prior authorization request for services.

CONSENT PROCESS

The Committee identified the process of obtaining consent for psychotropic medication as a barrier to treatment in Colorado's Child Welfare system. The prescriber is sometimes unclear who is responsible for giving consent and which parties need to be informed of the benefits and side effects associated with the medications. The prescriber must also have a complete medical/psychiatric history of the client to appropriately treat the needs of the child or youth. A more defined procedure will improve the treatment process by increasing the sharing of information by all parties involved.

The following guidelines are being recommended as a more streamlined and informed process to obtaining consent.

Proposed Process for Gathering Consent for Psychotropic Medications

When a child involved with the child welfare system is referred for psychotropic medications, the following process should be followed.

1. Before referring a child/adolescent to a provider for psychotropic medications, the child welfare worker should determine whether the individual(s) who has the legal right to consent for treatment will support the initiation of psychotropic medications. The child welfare worker should also identify individuals who may have relevant information about the child's/adolescent's medical and psychiatric history.

2. The child welfare worker should ensure that the child/adolescent is sent to the medical appointment with the Consent Form for Psychotropic Medications (Attachment B). When possible the child welfare worker should also:
    a. Provide information about child's/adolescent's medical and psychiatric history or the contact information for the individual(s) who may have relevant information about the child's/adolescent's medical and psychiatric history.
    b. Have the individual who has the legal right to consent for treatment, accompany the child to the medical appointment.

3. Before initiating psychotropic medications a medical history and a psychiatric assessment must be completed and refer to a behavioral health provider if necessary. Prescriber should obtain information from all relevant parties which may include, but is not limited to:
    a. Biological Parents
    b. Foster Parents
    c. Child Welfare Caseworker
    d. Schools
    e. Guardian Ad Litem (GAL)
    f. Court Appointed Special Advocate (CASA)
    g. Other medical and behavioral health treatment providers
    h. Others with significant knowledge of the child/adolescent

4. The prescriber develops a recommendation for a course of treatment.

5. The prescriber educates the child and all relevant parties (as defined above) on the child's/adolescent's diagnosis and treatment. **Ongoing communication with physical health and mental health professionals is essential.**

6. Obtain assent from the child/adolescent and consent from the individual(s) who has the legal right to consent for treatment. Contact the child welfare caseworker to determine who has the right to consent for treatment. Information needed to consent shall include:
    a. Information regarding risks and benefits of the medication
    b. Adequate dose, frequency of dose, and duration of the medication treatment
    c. Rationale for adding medication(s)
    d. Information about discontinuation of a psychotropic medication(s)

7. The prescriber shall reassess the child/adolescent if the child/adolescent does not respond to the initial trial of medication treatment as expected.

Uniform Consent Form

The Committee also recognizes that a more uniform consent form for psychotropic medications would be helpful to all parties involved. When treating children from multiple counties, prescribers may see multiple consent forms. Often times, these consent forms are not consistent and some do not capture all relevant information, such as what the medication is intended to treat, what benefits can be expected, and what side effects to look for. It is also important to verify that those involved in the case are giving *informed* consent, or for those involved in the case, but not responsible for giving consent, they also have been informed of side effects, etc. This should include the child or youth, who may not be able to consent, but can give their assent, showing that they understand the medications they have been prescribed. The Committee developed a template that captures all of these essential items. It is recommended that county departments, as well as prescribers, compare their current consent

forms to this template (provided in Appendix C) and either adopt this form or amend their form to capture the relevant information.

Turnaround Time

The Committee is recommending that a response to a request for medication consent should be completed within 24-hours for urgent requests and 48-hours for routine requests. All parties should understand the consequences of not meeting these timelines, including the potential for psychiatric hospitalization, unnecessary care and costs, and disrupted placements. A quick turnaround time is often needed to prevent disruption in placement or the need for a higher level of care, such as residential treatment or hospitalization. Preserving placements not only saves money, but more importantly, it saves children and youth from additional trauma.

CONCLUSION

The work of ensuring the appropriate use of psychotropic medications for Colorado's children and youth in out-of-home care and to integrate medications into comprehensive physical and behavioral health care is multi-faceted. There are many people that touch the lives of these children and youth and it is essential that they are all working together for the best possible outcomes. To that end, the Psychotropic Medication Steering Committee has made the following recommendations:

- Data and Safeguards
  - Review data of prescribing practices
  - Require prior authorization and drug utilization review on prescribing practices that raise red flags
  - HCPF communication with prescribers, facilitating the examination of current practices and collaboration with prescribers

- Communication and Coordinated Care
  - Implementing a medical home model through the Accountable Care Collaborative
  - Telemedicine for underserved areas
  - Improved system for transferring records
  - Special attention to transitioning youth
  - Consistent guidelines for a psychopharmacology assessment

- Consent
  - Streamlined consent process
  - Uniform consent form
  - Turn-around time for consent

The Committee continues to evolve and upon approval of the above recommendations, will move into the next phase of guiding the implementation of these recommendations.

APPENDIX A- Colorado AP 11-27-12

MEDICAID MEDICAL DIRECTORS
LEARNING NETWORK

Antipsychotic Medication Use in Medicaid Children and Adolescents — Colorado

Background

Supported by the Agency for Healthcare Research and Quality (AHRQ) since 2005, the MMDLN, as an integrated national resource, seeks to advance the health of Medicaid patients in over 40 member States and across the Nation while best stewarding available resources. The network is focused on the development and use of evidence-based medicine, measurement and improvement of health care quality, and the redesign of health care delivery systems.

The increased use of antipsychotic (AP) medications present quality and value challenges for payers, patients and clinicians. These challenges occur in the context of widespread need for mental health services for children and adolescents who face a variety of barriers to mental health evaluation and treatment.

In response to these concerns, this brief is a follow-up to the MMDLN's *Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide From a 16-State Study,* from 2004-2007 which can be found at: (http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html). Please reference this guide for variable definitions.

Methods

The rates of AP medication use in 9 of the 16 original States were defined and calculated similarly to the 16-State study. (However, Maine and Pennsylvania used a slightly different medication list than the other 7 States.)

- Calculated by dividing the number of medication users by the total populations each year (e.g. more than 1 month eligibility).
- Based on the 2008-2011 calendar year, we calculated the minimum, maximum, and median for the 9 States in order to examine trends.

Comparing calculations between this 9-State study and the 2004-2007 16-State study is not possible due to the absence of several large State populations. However, States with significant changes were asked to feature their programs, practices, and policies alongside the reported outcomes.

In 2011, we assessed antipsychotic (AP) and mental health drug (MHD) utilization in Colorado's State Medicaid program (414,880 enrolled children/adolescents). Key findings and trends are discussed below. Arrows indicate increase or decrease in use from 2008-2011.

Key findings from AP medication use in 2011

Among Medicaid enrolled children/adolescents, AP medication users comprise:

- 1.5% (6,128) of all enrolled children/adolescents (N=414,880) ↓
- 0.1% (167) of all enrolled children ≤ 5 years old (N=186,302) ↓
- 11.2% (761) of all enrolled foster care children/adolescents (N=19,934) ↓

Of the AP medication users:

- 3.4% (206) are at or above a maximum dose (i.e. Texas' foster care prescribing parameters) (N=6,128) ↓
- 21.6% (1,302) are prescribed multiple AP medications (≥2) (N=6,015) ↓
- 24.4% (1,336) have a >20-day gap in supply (N=5,474) Same ⟷

Key findings from Mental Health Drug (MHD) use in 2011:

- 4.8% (20,040) of children/adolescents enrolled in Medicaid were taking a MHD (N=414,880) ↑
- 13.0% (2,615) of users take multiple MHDs (≥4) (N=20,040) ↓

Colorado is taking a number of different approaches to improve the appropriate use of AP medications and MHDs:

Atypical antipsychotic (AAP) medications were added to the Preferred Drug List beginning April 1, 2010, and the class has since been reviewed annually. Quantity limits have been built into the pharmacy claims system starting in April 2010, requiring prior authorization for both max dose and doses per day in accordance with FDA approved dosing regimens for AAP agents. A restriction was put into place (April, 2010) requiring prior authorization for any new AAP medication prescription in children under 5 years of age. This prior authorization must be manually reviewed by a clinical health professional at the Department of Health Care Policy and Financing. Non-preferred products are limited to FDA approved indications only. With input from the Drug Utilization Review Board, an antipsychotic medication prescribing algorithm was created and made available through the Department Web site to assist prescribers in making product selections based upon indication and patient specific factors. The algorithm is now undergoing its second update with assistance from experts on the Board. The Department has worked with prescribers and behavioral health organizations to match child psychiatrists with prescribers for consults and referrals when necessary. Members of the Department of Health Care Policy and Financing are currently working with experts from the Colorado Department of Human Services and several State experts in pediatric mental health to produce the "Guidelines for Psychotropic Medications use for Children and Adolescents in the Child Welfare System."

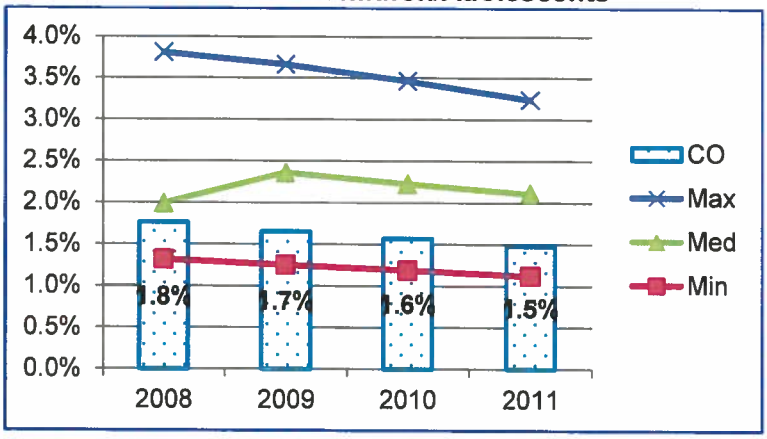
The MMDLN is funded by an AHRQ contract to AcademyHealth. The funding supports in person meetings, Web conferences, and other activities that help the members use evidence-based research findings to make policy decisions. The views expressed in this document do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the fact that AHRQ is funding this group imply endorsement of any publications or policy statements that come out from the MMDLN.

Compared to the 9-State average, Colorado has lower rates for both AP medication and MHD use. Similar to the 9-State average, the number of users in Colorado increased for older children/adolescents.

AP Medication and MHD Use by Age

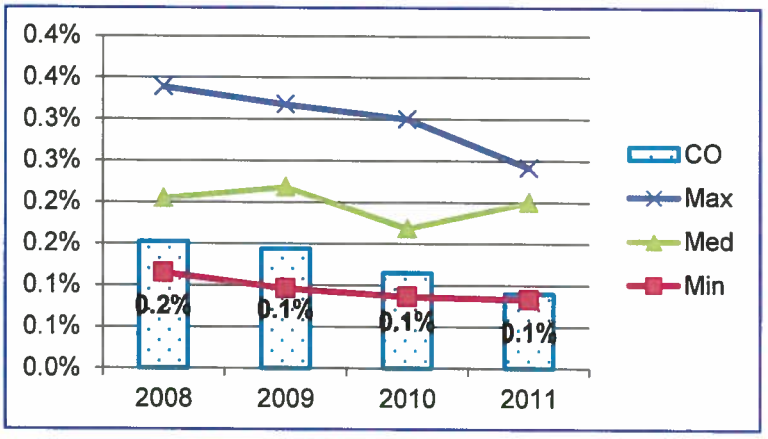
Age Years	All AP Users		All MHD Users	
	CO	9-State Average	CO	9-State Average
0-5	0.1%	0.2%	1.1%	1.8%
6-11	1.6%	2.3%	6.1%	9.4%
12-18	3.9%	4.4%	10.2%	13.8%

AP Medication Use in Children/Adolescents



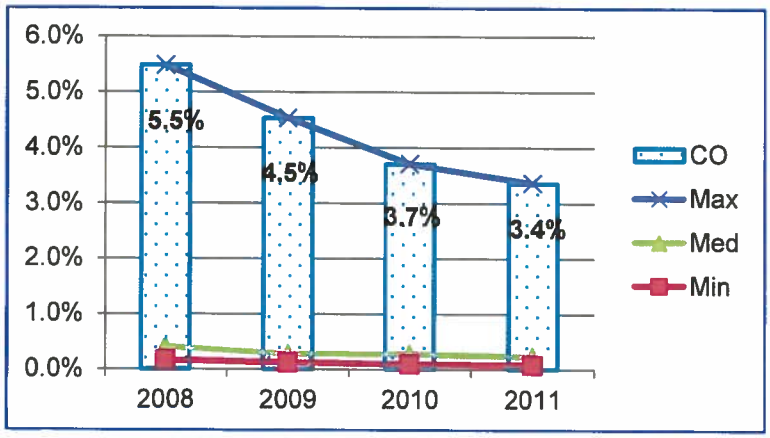
Within Colorado the percentage of children using AP medications decreased slightly from 2008-2011. The proportion was highest among the Foster Care (11.2%) and the 12-18 age group (3.9%).

Children Age Five Years and Younger Using AP Medications



In Colorado, the percentage of children age 5 and younger using an AP medication remained almost the same from 2008 to 2011. In 2011, Colorado had the lowest rates on this measure compared to the other eight States during this time period.

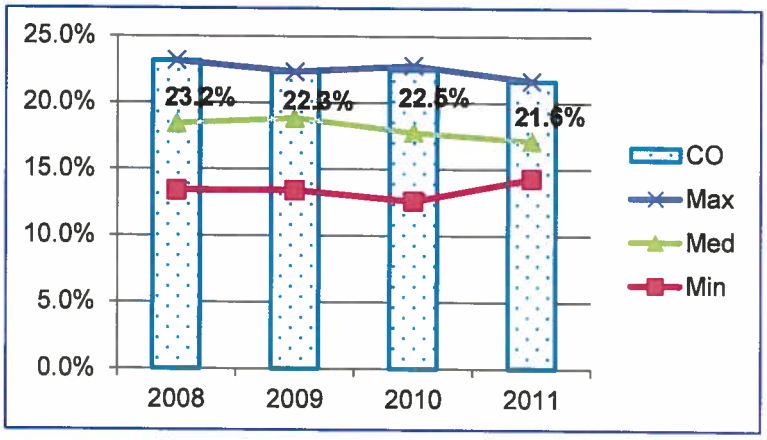
Children/Adolescents Prescribed a High Dose of AP Medications



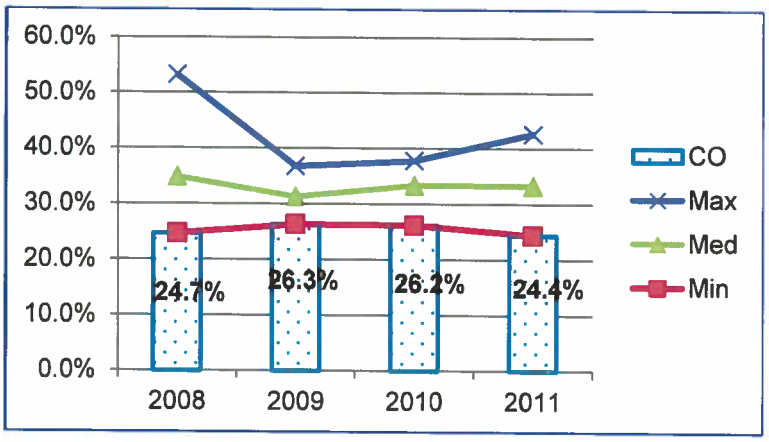
In Colorado, the percentage of children/adolescents prescribed AP medications at two or more times the maximum dose decreased between 2008 and 2011, but remained the highest rate for this measure among the 9-States. In 2011, rates on this measure were highest among the age 6-11 (6.4%), followed by foster care (4.3%).

Children/Adolescents Using Two or More AP Medications

In Colorado, the percentage of children/adolescents prescribed two or more AP medications decreased between 2008 and 2011. Rates on this measure were highest in Colorado among the 9 States. In 2011, rates on this measure were highest among the foster care (25.5%), and 12-18 years age group (23.0%).



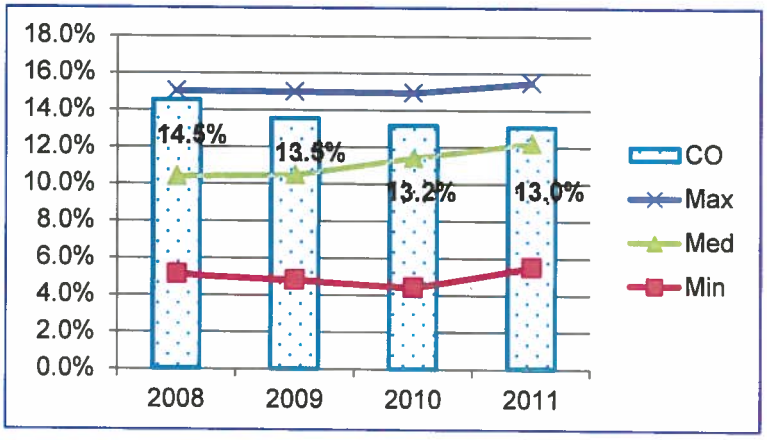
Children/Adolescents with More Than a 20 Day Gap in AP Medication Supply



In Colorado, the percentage of children/adolescents with a gap in supply of greater than 20 days between consecutive AP medication prescriptions fluctuated between 2008 and 2011. In 2011, rates on this measure were highest among the age 6-11 years age group (28.0%).

Children/Adolescents Using Multiple Mental Health Drugs

Within Colorado, the percentage of children/adolescents using multiple (four or more) MHDs decreased slightly between 2008 and 2011. In 2011, rates on this measure were highest among the foster care (24.3%), and 12-18 years age group (15.7%).



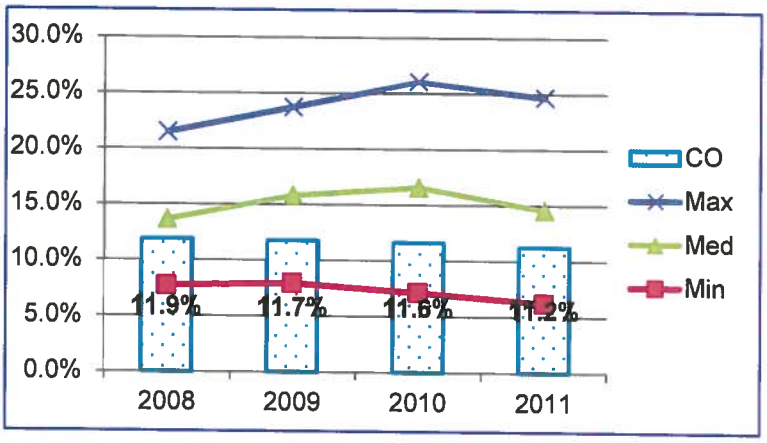
AP Medication and MHD Use in Foster Care

Foster Care and Non-Foster Care AP and MHD Users

Foster Care Status	AP		MHD	
	CO	9-State Average	CO	9-State Average
Foster Care	6.2%	14.0%	20.8%	26.6%
Non-Foster Care	1.0%	1.8%	6.0%	7.4%

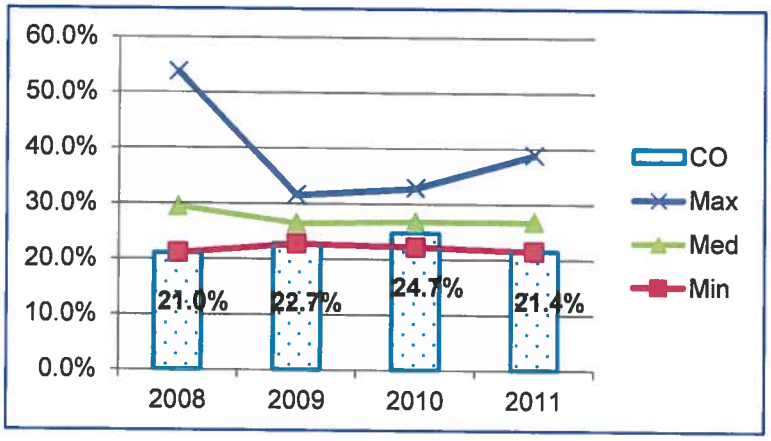
Compared to the 9-State average, Colorado had a lower percentage of foster care children/adolescents using AP medications or MHDs.

Foster Care Children/Adolescents Using AP Medications



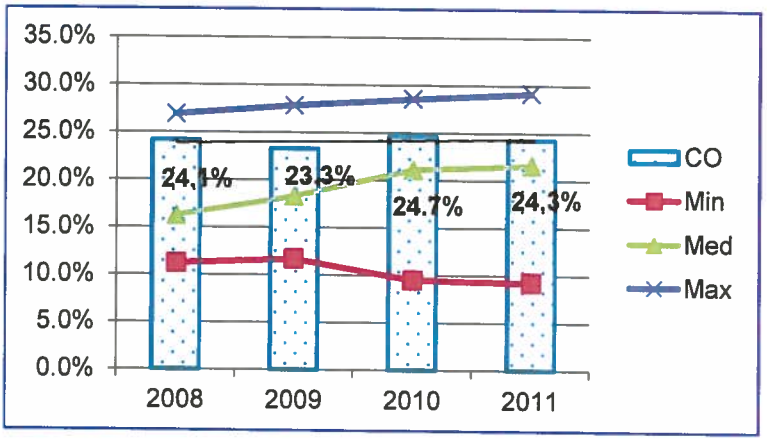
The percentage of children/adolescents in foster care using AP medications in Colorado was lower than the 9-State median across time. Overall, the proportion decreased slightly from 2008 to 2009.

Foster Care Children/Adolescents with More Than a 20 Day Gap in AP Medication Supply



In Colorado, the percentage of children/adolescents in foster care with more than a 20-day gap in AP medication supply fluctuated between 2008 and 2011. The rate of this measure was one of the lowest across time among the 9 States.

Foster Care Children/Adolescents Using Four or More MHDs



In Colorado, children/adolescents in foster care using multiple (four or more) MHDs fluctuated across 2008 and 2011 and remained slightly above the 9-State median over this time period.

9 States: Colorado, Maine, Missouri, New Hampshire, New York, Oklahoma, Pennsylvania, Tennessee, Colorado

APPENDIX B- Fact Sheets

What Do Providers need to know about the ACC?

Accountable Care Collaborative "101":
Coordinating Services between the Child Welfare System, Primary Care Medical Homes and the ACC

What is the Accountable Care Program?
The ACC is a Medicaid program to improve clients' health and reduce costs. Medicaid clients in the ACC receive the regular Medicaid benefit package and are enrolled in a Regional Care Collaborative Organization (RCCO). Medicaid clients also choose a Primary Care Medical Provider (PCMP).

Central Goals:
• Improve health outcomes through a coordinated, client-centered system; and
• Control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources.

Key Components:
Seven Regional Care Collaborative Organizations (RCCOs) provide:
- Medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
- Care coordination among providers and with other services such as behavioral health, long-term supports and services, Single Entry Point (SEP) programs and other government social services such as food, transportation and nutrition; and
- Provider support such as assistance with care coordination, referrals, clinical performance and practice improvement and redesign.

What does this mean for me as a provider to children in the child welfare system?
- RCCO staff provides you with care coordination, as needed.
- RCCOs and the assigned PCMP have the ability to see Medicaid paid claims that can help providers determine where a child has been seen in the past. This will speed up the search for medical and behavioral health records that may be needed by providers for immediate and urgent treatment needs.
- RCCOs have the ability to access claims for behavioral health and pharmacy.
- The RCCO staff can assist with locating available physical, oral and behavioral health providers and other medical and non-medical community supports for the family and the child/youth.
- RCCO staff can assist with coordination between physical health and behavioral health and can help arrange for services.
- RCCO staff can assist when physical health services or supports are denied or partially approved.
- RCCO staff can help you with prior authorization issues, available benefits and services and access to medically necessary care.
- RCCOs can help access EPSDT services and supports as needed to meet federal requirements.

The RCCO staff are only available during regular business hours.

If you are a part of a hospital system, you may also have access to the Colorado Regional Health Information Organization (CORHIO), which may help locate information about emergency room visits and other hospital-based services before the information becomes available within Medicaid's claims system. CORHIO is a nonprofit, public-private partnership that is improving health care quality for all Coloradans through cost effective and secure implementation of health information exchange (HIE). CORHIO is designated by the State of Colorado to facilitate HIE.

CORHIO works closely with and among communities across Colorado to develop and implement secure systems and processes for sharing clinical information. CORHIO collaborates with health care stakeholders including physicians, hospitals, clinics, mental health, public health, long-term care, laboratories, imaging centers, health plans and patients.

To see if you are eligible for this service, please visit http://corhio.org/contact-us.aspx.

Accountable Care Collaborative and Child Welfare Case Workers

ACCOUNTABLE CARE COLLABORATIVE "101" FOR THE CHILD WELFARE CASE WORKER

What is the Accountable Care Collaborative?

The Accountable Care Collaborative (ACC) is the new delivery system for Medicaid in Colorado. "Colorado is one of a handful of states piloting innovative health care payment and delivery reforms through Medicaid. Under the Accountable Care Collaborative Program, which began enrollment in May 2011, the state Medicaid agency contracts with seven regional organizations to create networks of primary care providers and ensure care coordination for Medicaid enrollees. Providers receive increased payments, and will eventually be eligible for incentives and shared savings and risk agreements. Results from November 2012 show reduced use of acute care, better control of chronic conditions, and lower total costs among enrollees."[1].

The ACC is a Medicaid program to improve clients' health and reduce costs. Medicaid clients in the ACC receive the regular Medicaid benefit package, and are enrolled in a Regional Care Collaborative Organization (RCCO). Medicaid clients also choose a Primary Care Medical Provider (PCMP).

Central Goals

• Improve health outcomes through a coordinated, client-centered system; and
• Control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources.

Key Components:

Seven Regional Care Collaborative Organizations (RCCOs) provide:

- Medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
- Care coordination among providers and with other services such as behavioral health, long-term supports and services, Single Entry Point (SEP) programs and other government social services such as food, transportation and nutrition; and
- Provider support such as assistance with care coordination, referrals, clinical performance and practice improvement and redesign.

What do I need to know about this program?

The ACC is not a traditional managed care program. While children are assigned to a provider, they are not locked into that provider and may see any provider who accepts Medicaid. The child's provider, along with the name of the RCCO, will appear on the eligibility print out from Medicaid.

Children in child welfare are passively enrolled into a RCCO. They are assigned to the last provider they may have visited and a list of these assignments is forwarded every month to the county who

[1] The Commonwealth Fund, **Authors:** Diana Rodin, M.P.H., and Sharon Silow-Carroll, M.B.A., M.S.W

has custody. If you or your manager is not receiving a copy of this list, please send an email to Catania Jones at Catania.jones@state.co.us and request to be added to the distribution.

How does being in a RCCO benefit the children/youth on my caseload?

- When you need assistance with a child, including but not limited to:
    - Facilitating the location of medical records, including immunization records, and behavioral health treatment records.
    - Locating providers such as physical, oral health and behavioral health providers and specialists
    - Locating community services
- RCCO staff can help you meet the required medical and dental visits; coordinate physical health and behavioral health; and can help arrange for services, as needed.
- RCCO staff can help when services or supports are denied or partially approved.

A child must be enrolled in the ACC in order to utilize ACC care coordination services.

What do the RCCOs need from me as the case worker?

- Serve as the focal point of contact for releases
- Information on choice of care and if the child is placed out of the county or service area

For more information on the ACC, including a listing of the ACC contracts and their service areas, please visit: www.colorado.gov/hcpf and enter Accountable Care Collaborative in the search engine.

ACC Case Workers and Child Welfare Programs

CHILD WELFARE "101" FOR THE ACCOUNTABLE CARE CARE COORDINATOR AND PROVIDERS

Child Welfare - Program Description
Child Welfare is a division of the Colorado Department of Human Services and is located in the Office of Children, Youth and Families. It consists of a group of services intended to protect children from harm and to assist families in caring for and protecting their children. Taken together, these programs comprise the main thrust of Colorado's effort to meet the needs of children who must be placed or are at risk of placement outside of their homes for reasons of protection or community safety. The delivery of Child Welfare Services in Colorado is primarily a state-supervised, county administered system.

Division of Child Welfare Vision:
Colorado's children live in a safe, healthy and stable environment.

Mission:
Everything we do enhances the delivery of child welfare services so that Colorado's children and families are safe and stable.

What do you need to know about this program?

Children in the child welfare system are required to have the following services:

- A full medical examination scheduled within fourteen (14) calendar days after initial placement.
- A full dental examination scheduled within eight (8) weeks after initial placement.
- Ongoing medical and dental care is to be provided in a timely manner.
- A regular schedule of appointments should be maintained in subsequent placements.

County child welfare departments are required to document these appointments in the case record.

Children may have a need to have additional services, such as additional well child visits, oral health care visits, or screenings. Please see AAP recommended schedule at http://www2.aap.org/fostercare/.

Responsibility:

Children in child welfare are typically in county custody and the county department is typically the entity to provide any consent to treat.

Children may move in and out of service areas across the state. Regional Care Collaborative Organizations (RCCOs) must work together to serve a child effectively.

Is important to remember in Colorado that:

- 98 percent of children in the child welfare system have been exposed to trauma or a traumatic event.
- The average length of stay in the child welfare system is 25.3 months.
- With multiple placements, the child may have more complex needs and require higher levels of coordination and communication among all providers.

Therefore, RCCOs should work with the county case worker to ensure that the child's physical, dental and mental health needs are being met without duplicating services as children move between placements.

Relationships:
RCCO staff and providers are expected to coordinate and communicate with DHS case workers to assist with data collection, medical records and any other information DHS staff may be required to add to their data system.

Child welfare staff is expected to provide releases, HIPAA information and any available medical or social information needed to treat the child quickly and effectively. The RCCO is a contractor of the Department of Health Care Policy and Financing and should be treated as such for HIPAA.

For more information, go to: www.colorado.gov/cdhs

APPENDIX C-

Proposed Consent Form for Psychotropic Medications

Child/Youth's Name: _____ DOB: _____

Date:_____ Psychiatric or Medical Provider: _____

These are the current medications:

_____ _____

_____ _____

_____ _____

_____ _____

New medications being prescribed are:

_____ _____

_____ _____

_____ _____

_____ _____

I have been informed of:

□ My diagnosis

□ The name of the medication prescribed

□ The reason the medication was prescribed

This medication is intended to address the following symptoms:

_____

_____

(□ Check if medication information sheet attached instead)

□ Usual use of the medication (*Adequate dose, frequency of dose, and duration of the medication treatment, maximum recommended dose*)

□ Description of the benefits expected

□ The common side effects

□ The risks of taking the medication

□ The probable consequences of not taking the medication

□ Alternatives to the medication

□ My right to obtain a second opinion

Printed information was provided to the family or caregiver on _____.

(Consent Form Continued)

In the event of a life threatening adverse reaction, seek emergency care.

In the event of a non-life threatening adverse reaction, if you are unable to contact your health care provider, seek emergency care.

Do not discontinue the routine use of medication without the prescribing clinician's instructions, as this could be hazardous.

For a Child or Adolescent Under 15

I understand the child cannot be compelled to take this medication and I may request the discontinuation of the medication.

I also understand that there are no guaranteed results of this medication.

I understand the benefits and the risks of this medication. On this basis, I give consent for the medication to be administered as prescribed.

_____ _____

Signature of Parent or Legal Authority Relationship

_____ _____

Signature of Youth Indicating Informed Assent Date

_____

Child Welfare Administrator (*if the parent has not consented, please check one of the options below*)

□ Parent Unavailable
□ Parent Refused

For Adolescent 15 Years or Older

I understand I cannot be compelled to take this medication and I may request the discontinuation of the medication.

I also understand there are no guaranteed results of this medication.

I understand the benefits and the risks of this medication. On this basis, I consent to treatment.

_____ _____

Signature of Youth Date