STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

May 19, 2023

GENERAL LETTER NO. 18-C2-7

ISSUED BY: Bureau of Child Welfare and Community Services
Division of Family Well-Being and Protection

SUBJECT: Employees' Manual, Title 18, Chapter C(2), ***Case Management***, Contents 3, 77-83, revised.

Summary

This chapter is revised to reflect licensed foster care clothing allowance increase.

Effective Date

Immediately.

Material Superseded

Remove the following pages from Employees' Manual, Title 18, Chapter C(2), and destroy them:

Page	Date
Contents 3	December 16, 2022
77-83	December 16, 2022

Additional Information

Refer questions about this general letter to your area service administrator.

Page

- Assurance that the Department coordinated with the appropriate local AEA to identify how the children can remain in the educational setting in which the children were enrolled at time of placement. Children should remain in the school they were enrolled in at time of placement unless it is determined it is not in their best interest. Lack of transportation shall not be a barrier to a child remaining in the school the child was attending when he or she entered foster care.
- Assurance that if it was determined that it was not in the children's best interest to remain in the setting in which they were enrolled at the time of placement, that the affected educational agencies immediately and appropriately enrolled the children in another educational setting.
- Assurance that if the children changed their education setting, their educational records were provided for use in their new educational setting.

Multiple documents about foster care and education may be found on the DoE website: https://www.educateiowa.gov/education-children-foster-care

Clothing Allowance

When in the judgment of the social work case manager or child protection worker, clothing is needed by a child who has been placed in foster care, an allowance may be authorized to purchase clothing. For these purposes, foster care includes children placed out of home by court order or voluntary placement agreement (VPA) in licensed foster care, Qualified Residential Treatment Program (QRTP), shelter, or Supervised Apartment Living (SAL).

Since the child's parents are primarily responsible for the cost of the child's care, first approach the parents to supply the needed clothing. If clothing is not available from the child's family, explore the child's financial resources, including the child's escrow account, if any. If no resources exist, a clothing allowance can be authorized.

As a case is transitioned from the child protection worker to the social work case manager, the social worker case manager should communicate with the child protection worker and others to ensure need for clothing has been assessed and clothing is purchased, with payments resolved using the process descried in this section.

Maximum amounts are $500 per year for a child through age 12 and $750 per year for a child age 13 and older. The clothing allowance may be provided in addition to the maintenance payment. The maximum amount is reset annually based on the date the episode of foster care began. Placement changes while in foster care do not reset the maximum amounts.

The social work case manager should consider the clothing needs of a child entering foster care and evaluate and authorize additional clothing allowance when the child needs clothing to replace lost clothing or because of growth or weight change. The social work case manager should only approve what is needed at the time in case the child may need additional items at a later point. Clothing purchased with the clothing allowance goes with the child when their placement changes.

When clothing is purchased by a foster care provider, the provider is expected to submit receipts to the social work case manager within 30 days of purchase for auditing purposes, using Form 470-1952.

The social work case manager obtains the provider's signature and submits the form to the worker's supervisor. The supervisor checks the receipts against the clothing items listed and the cost of the items, the total, tax, and total costs for accuracy before approving and signing the form. Document this determination in the case record. Generate reimbursement through the FACS system Special Issuance List (SPIL) screen. See manual chapters 18D(1-4) for program specific information.

Promoting Placement Stability

Placement stability is the maintenance of continuity in a child's living situation in terms of the adults they live with and the ability of a child to grow up with their siblings. Children do better when they have stable relationships with loving caregivers who are able to meet their needs.

The more stability a child has, the more likely it is that the child will be able to develop enduring relationships with adults who care about them. It also enables a child to establish a stronger and more varied network of social support to help meet emotional as well as more concrete needs such as a job search or locating housing.

A child removed from the family home should be living in a safe, appropriate, and permanent home within 12 months of removal with only one interim placement. If, for the reasons of child protection, psychiatric treatment, or juvenile justice service, a child is in a temporary setting or unstable situation, then prompt and active measures must be taken to restore the child to a stable situation. (Source: Foster, Ray, *Quality Service Review*, Human Systems and Outcomes, Inc., April 2000.)

Evaluate the quality of the child's continuing relationship with family members or other meaningful persons periodically. Determine whether the child requires help to work through any conflicts or changes in these relationships.

Children with individual behavioral issues and physical and mental health challenges have been linked to greater placement instability. Specialized behavioral health supports and services should be available to children and their caregivers throughout the placement process.

Stress situations may cause the child to need special help. These include:

- Loss due to separation (including termination of the placement)
- Medical care
- Hospitalization
- Other unavoidable disturbing experiences
- Changes in the plan for use of foster care services
- School or social problems

Give special attention to minimizing changes affecting the relationship of the child and significant adults. These include changes in frequency of contact with the SWCM, transfer of the SWCM, vacations of SWCMs or foster parents, or the child's departure from foster care.

Such changes reactivate in the child fears of separation and change. They may lead to emotional upset or disturbances in behavior that may harm relationships with the foster family, school, friends, and

birth family. With adequate preparation for changes and clarification of the reasons for it, the child will be better able to respond appropriately.

Negative impact of placement increases with multiple placements. Changing homes because of placement disruption compounds the sense of loss children face each time they end relationships with their caregivers. Placement disruptions can increase stress related responses. You are responsible for minimizing multiple placements. The failure of a placement is the failure of the service delivery system to meet the needs of the child, not the failure of the child.

The individualized case permanency plan shall identify whether a child is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Minimize placement breakdown by:

- Adequately assessing the emotional, physical, and behavioral needs of the child.
- Matching the child needs with the resource family's or facility's abilities.
- Preparing the child and family for the placement.
- Assisting children with feelings about living apart from families.
- Providing adequate support to the child, family, and resource caregivers.
- Scheduling regular meetings with the child's foster family.
- Maintaining family connections by allowing interactions early and often.
- Developing crisis plans that address predictable behaviors or patterns of behavior that threaten or destabilize the placement.
- Recognizing relationship stress early and responding to resolve problems.

Coordination of Contracted Services With Placement Setting

FCS contractors are expected to communicate with the child's placement setting in order to coordinate responsibilities and case service planning.

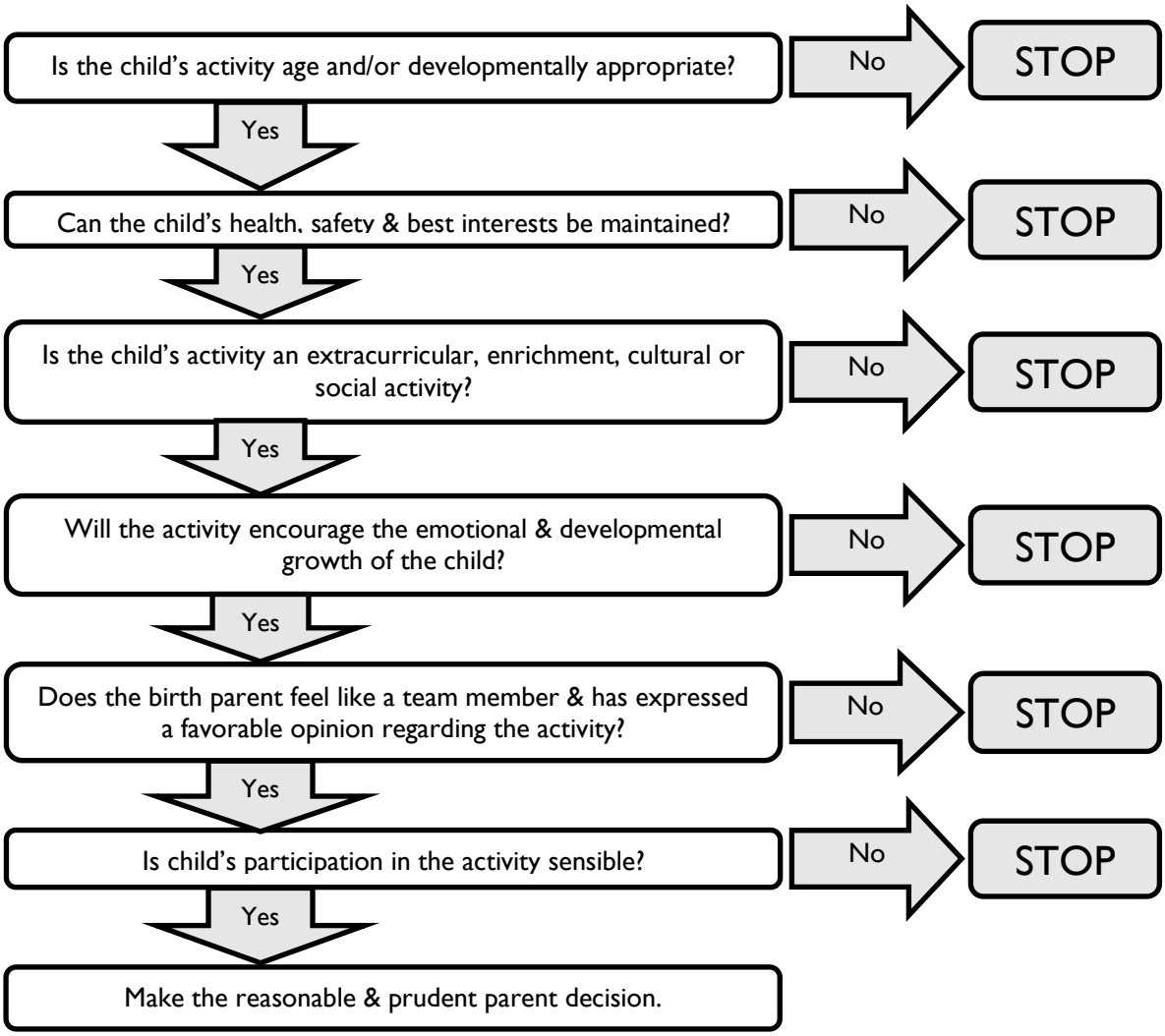
The SWCM should ensure and direct the FCS contractor regarding coordination with the placement setting. Areas in which to direct this coordination include, but are not limited to:

- Planning for participation by the child and the placement staff in solution focused meetings.
- Planning for children's attendance in court hearings.
- Planning and transportation arrangements for parent-child and sibling interactions and visits.
- Case crisis responses to situations that develop while the child is participating in family interactions.
- Collaborative planning around reunification activities and the timetable for returning the child home or moving toward another permanency option.
- Coordination with the foster care RRTS contractor to ensure supports are provided to the resource family so that they are able to support the permanency goal.

Reasonable and Prudent Parent Standard for Foster Children

Foster parents and child-care institutions caring for children placed out of the home are able to apply the Reasonable And Prudent Parent Standard for the foster child to participate in age-appropriate and developmentally appropriate activities. Discuss with the foster child, their parents, or caretakers, what activities would be the most interesting and appropriate. Then work to make those activities possible for the foster child. While the child's parents or caretakers may disagree with the foster parents' decision, after they have considered their input, the decision rests with the foster parent. Document this discussion in the case narrative.

Child-care institutions are required to have an on-site official authorized to apply the reasonable and prudent parent standard to decisions involving the participation of the foster child in age-appropriate or developmentally appropriate activities. Check with the facility to know who makes such decisions and discuss with that person their intentions for the foster child to participate in age-appropriate and developmentally appropriate activities.



The above diagram is intended only as a basic guide for making a reasonable & prudent parent decision by the caregiver per Public Law 113-183, Preventing Sex Trafficking & Strengthening Families Act. The caregiver should obtain the details of the activity, and explain to the child the expectations they have for them to participate in the activity.

Monitoring Health and Mental Health Care for Children in a Foster Care Placement

It is critical and federally mandated to monitor any health and mental health care needs of a foster child to ensure these needs are being met. Each foster child should be assessed by a clinician for their mental health needs and preferably a Pediatrician for their health care needs. SWCMs monitor any needs identified in these screenings through collateral contacts with providers, foster parents or QRTP staff, biological parents, and Department contractors. Most health care providers have electronic medical records. A foster care provider may ask for a "summary of the visit" or discharge/referral form at the end of a health care visit. If a health care provider does not have electronic medical records, the foster care provider should give the health care professional form *470-0580, Physical Record* to complete. SWCMs should review this and any other documentation regarding the child's health or mental health.

Monitoring health and mental health care is an ongoing process throughout the foster care placement. At each foster care monthly visit, the SWCM should ask for updates regarding any dental, medical, or mental health appointments as well as any recommendations or follow up resulting from these appointments.

The SWCM should document this information in the child's Face to Face and Contact Notes. All medical and mental health information should be included in any court report narrative, case narrative, and in the Case Permanency Plan.

Communication with Managed Care Organizations (MCOs)

MCOs are required to complete a Health Risk Assessment (HRA) on every child in placement. Foster parents and kinship caregivers do not have the authority to release the information needed for the HRA. It is the SWCM's responsibility to help facilitate the completion of the HRA by providing needed information when the MCO case manager reaches out. No release of information is required for the SWCM to provide pertinent information to the MCO case manager for the completion of this assessment. The HRA is completed within 90 days of enrollment with the MCO, on an annual basis, and when there is a change in health status for members. The purpose of this assessment is to get a self-reported picture of the member's whole-person health so that they can be connected with case management services if appropriate, in addition to any other resources the member may need to improve their heath and overall wellbeing. The assessment takes approximately 10 minutes to complete.

Consenting to Medications

If the Department is the custodian of the child in a foster care placement, the SWCM should contact the child's parents or guardian to inform them of the medication recommendation. The best practice is to invite the child's parents or guardian to the child's evaluation or medical appointment. This enables the parents or guardian to directly ask the prescriber any questions they may have and to discuss any concerns.

If the child's parents or guardian do not attend the evaluation or medical appointment, contact them and discuss the medication recommendation to obtain their consent. Foster care group care providers need to also discuss medication recommendations with the child's parents or guardian before the prescribed medication is obtained and given to the child.

When the Department is the guardian of the child in a foster care placement, the SWCM should discuss with their supervisor if they should consent to the recommended medication before the caregiver fills the medication prescription and administers it to the child.

Monitoring Medications

The SWCM needs to inquire of the caretaker at each visit as to over-the-counter and prescribed medications that have been administered to the child, including any negative reactions (side effects) to the medication by the child or if the medication is helping the child. Any medications, prescribed or over-the-counter, administered need to be documented in the case permanency plan, court report narrative, and the case narrative. Document the medication prescribed for the child, what the medication is prescribed for (e.g. diagnosis), and the dosage. Also document any new medication prescribed or if a medication changed.

In addition, the SWCM should ensure that a child is seen regularly by the prescribing physician or mental health professional to monitor the effectiveness of any medication, to assess any side effects, to monitor any health implications, to assess any needed medication changes, and to determine if the medication is still necessary or if other treatment options are more appropriate.

Ask the child if they have an understanding why they are taking medication and if they have any concerns about the medication. If there are concerns, you must advocate on the child's behalf to have the medications reviewed and explore alternatives to medication.

Addition information regarding medications maybe found at:
http://www.nlm.nih.gov/medlineplus/druginformation.html

Monitoring Psychotropic Medication

Ensuring the appropriate use of psychotropic medication for children in foster care requires vigilant monitoring and oversight. Psychotropic medications are used to treat emotional and behavioral health symptoms and disorders. They primarily act on the central nervous system where they affect brain function, resulting in changes in perception, mood, consciousness, cognition, and behavior. Most children in foster care never need psychotropic medications.

While they are traumatized by abuse and may show negative behaviors or signs of emotional stress, these are normal reactions to what they have been through. All children act out at different stages of their lives and most children will gradually heal in an appropriate environment and with consistent interventions.

However, the use of psychotropic medication in the foster care population is higher than in the general population. While some children may benefit from medication to treat certain mental health diagnoses, these medications may be harmful if used inappropriately. Medications do not treat trauma which is often triggering the emotions and behaviors. Working with a qualified mental health professional regarding trauma-informed mental health services is best practice for addressing concerns without the inappropriate use of psychotropic medication.

Part of monitoring psychotropic medication involves being aware of "red flag" prescribing practices. These are practices that do not follow the recommended FDA guidelines for prescribing psychotropic medications to children. Red flag practices for prescribing psychotropic medications include:

- Prescribing multiple medications at the same time;
- Prescribing multiple medications before a trying a single medication;
- Prescribing to children under the age of 6; and/or
- Prescribing a dosage that exceeds recommendations.

The Department monitors the red flag practices of prescribing to children under the age of six and prescribing multiple medications at the same time through a quarterly report. This report is sent out to the social work administrators to distribute to the applicable supervisors and then to the SWCM. SWCM follow up to receiving information that a foster child on their caseload is in the report includes:

- Verifying that the report accurately reflects the psychotropic medications the child is taking;
- Verifying that appropriate and sufficient mental and behavioral health services were provided to the child before medication was prescribed;
- Verifying that other treatment options are being explored; and
- Verifying that physical and mental health monitoring is occurring as recommended for the medication prescribed.

The SWCM should then update the case file with current information and document all corresponding case management activities related to medication monitoring in the Face to Face and Contact Notes. A copy of the quarterly medication report should be placed in the child's file.