STATE OF IOWA DEPARTMENT OF

Health AND Human SERVICES

FFY 2020-2024
Child and Family Services Plan
Health Care Oversight and Coordination Plan

June 2023

IOWA
HHS

FFY 2020-2024 Child and Family Services Plan

Health Care Oversight and Coordination Plan

STATE OF IOWA

IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF FAMILY WELL-BEING AND PROTECTION

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A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice

If a child coming into care has not had a physical health screening prior to placement, scheduling of the initial physical health screening occurs within 14 calendar days of the child coming into care. After the initial physical, children in foster care have physicals on an annual basis, or in accordance with applicable Medicaid periodicity schedule for health exams, according to the age of the child. While aware that not all social work case managers (SWCMs) ask the foster home or foster group care facility at monthly visits about the foster child's health care, the Iowa Department of Health and Human Services (HHS) central office staff plans to obtain an Iowa Medicaid Enterprise (IME) report. This report would separate out the children in foster care from the total number of children in the Core Set of Children's Health Care Quality Measures, which is one way to measure health outcomes for children insured under Medicaid. A SWCM's supervisor would receive the report to provide and discuss with the SWCM, as necessary. This is an ongoing process as currently there is not enough core data to see any trends. HHS will continue to monitor and will address in policy as a need is identified.

None of the five Service Areas reported utilizing telemedicine to complete the initial physical health screening or additional physical exams during the Pandemic.

How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home

Children have a physical upon removal with a medical professional, which identifies their health needs including emotional trauma associated with their abuse and removal from the home. SWCMs engage medical professionals in screening for the child's health needs. Considerations include but are not limited to:

- What behaviors are we seeing?
- Do they need behavioral health intervention services (BHIS)?
- What does the needs assessment tell us?
- Why is HHS involved with this child and family?
- What issues for specific children are noted and from what source, i.e., caregiver, family centered services (FCS) provider, HHS, SFM participants, therapist, or the child him or herself?

All of this information helps to determine the child's treatment plan. SWCMs rely on the child's medical professionals' expertise and recommendations for treatment.

SWCMs monitor the child's health care needs identified in the child's screenings, through documentation of medical care received and the effectiveness of their treatment plan, including appropriateness and sufficiency of the therapeutic services for meeting their needs. The SWCM monitors the child's health care treatments and therapy by reviewing the foster parent's documentation and the foster group care provider's health reports sent to them, and through discussions with the child and foster care provider.

How medical information for children in care will be updated and appropriately shared, which may include developing and implementing an electronic health record

Most health care providers have electronic medical records. The foster care provider may ask for a "summary of the visit" or discharge/referral form at the end of the health care visit if it is not automatically provided. If the health care provider does not have electronic medical records, the foster

care provider can give the provider the Physical Record form and request it be completed and returned to them. The Physical Record form includes a list of previous diseases that can be checked and dated, chronic illnesses and an area to list medications prescribed, physical examination information including vision, hearing, dental and mental health, and an area to complete preliminary diagnosis and recommendations, including any recommendations for further assessment or evaluation. The foster parent provides the Physical Record form, "summary of the visit", and other additional documentation of the child's health care to the SWCM.

Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care

HHS continues to work on assuring that the health care records follow the child when they move to another placement outside of their medical home or leave foster care. The Psychotropic Medication Advisory Committee has a smaller work group evaluating potential options to make recommendations on a more streamlined process. Several options have been explored by the committee over the last year. However, the nature of our systems has been a challenge on all sides. Currently, our systems are not connected or updated enough. As our new CCWIS system is built out we will continue to evaluate these options.

The Integrated Health Home (IHH) continues if the MCOs approve it. An IHH is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience. Children with a SED and their families receive IHH services using the principles and practices of a System of Care model. The IHH serves individuals enrolled in Medicaid, which includes those receiving targeted case management (TCM) and case management through Medicaid-funded habilitation as well as those not currently receiving care coordination. There have been adjustments made to IMPA which allows for both the MCO and HHS case managers to obtain contact information on one another.

The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications

Medication monitoring at the agency level

The IME data warehouse sends a quarterly report to the Bureau Chief for Service Training and Supports for each of the five HHS Service Areas for agency level medication monitoring. The IME also sends a similar report to the Chief JCO for distribution to the other Chief JCOs for agency level medication monitoring of JCS children in foster care. The psychotropic medication report serves as a "red flag". It identifies any children who are under age 6 and prescribed psychotropic medications, and children over age 6 prescribed two or more psychotropic medications. Appendix A outlines this information conveyed to the assigned worker's specific case management duties. If the situation does not involve a child under age 6, or a child prescribed two or more psychotropic medications, Iowa does not have a specific indicator to identify off label uses at this time. Additionally, HHS worked with the IME regarding data and process for the monitoring of psychotropic medication for the children and youth in foster care. The IME developed a metric for measuring child psychotropic use in foster care and added it to their overall strategic plan for HHS. This will allow for data information sharing regarding percentage of children and youth in foster care prescribed psychotropic medication, related demographics, and additional red flag practices. HHS anticipated that development of a process for the IME to communicate

that information to HHS would occur over SFY 2021. However, this process was more complicated than anticipated and has stopped until CCWIS is able to work directly with MCOs. The IME added performance measures to the SFY 2021 MCO contracts that address outcomes regarding the use of psychotropic medications in children on Medicaid. While HHS does not yet have access to that data, the performance measures on a systematic MCO outcome level should assist with prescriber level concerns. The Psychotropic Medication Advisory Committee is currently working on getting better data and this will be built out as the data is obtained. Obtaining data has been a challenge due to system issues. The committee continues to work on this issue, and we anticipate that the new CCWIS system will help. This is expected to be deployed over the next two years.

Medication monitoring at the client level

Foster parent level: HHS works with the five service area recruitment, retention, support, and training (RRTS) providers to provide training to foster parents on medications:

- understanding what the medication is;
- what the medication is used to address;
- possible side effects of the medication;
- when to contact the child's doctor if there is a problem with the medication or the child's reaction to the medication;
- description for what a psychotropic medication is;
- when to contact the child's SWCM;
- possible alternatives to medications; and
- how the foster parent can advocate for the best interest regarding the child's health care needs.

Foster parents are part of Iowa's collaborative team in monitoring medications and the health care needs of children in foster care. The foster parent monitors for side effects and contacts the prescribing doctor if there are side effects or the medication does not address the issue for which it was prescribed. The foster parent also keeps the child's case manager informed of the medications and any issues with it. Additionally, some HHS SWCMs go with the foster parent when the child goes to their health care provider.

SWCM level: The Social Work Administrator (SWA) distributes a quarterly psychotropic medication report to the SWCM's supervisor who reviews the report before disseminating it to each SWCM.

The juvenile court services (JCS) quarterly psychotropic medication report is similar in structure and content as the HHS quarterly report. The Chief JCO ensures their quarterly report gets to the appropriate JCO supervisors who review them prior to disseminating to each JCO. The psychotropic medication report (Appendix A) outlines the response expectations for SWCMs and JCOs, which central office staff sends to the local office for regular follow-up. Staff has the responsibility to ensure the mental health needs of children in out-of-home care are met, including the oversight of medication prescribed for mental health. Appropriate oversight includes, but is not limited to:

- Ensuring that a child regularly sees a physician or psychiatrist to monitor the effectiveness of the medication, assess any side effects and/or health implications, consider any changes needed to dosage or medication type, and determine whether medication is still necessary and/or if other treatment options would be more appropriate.
- Regularly following up with foster parents/caregivers about administering medications appropriately, and about the child's experience with the medication(s), including any side effects.

Oversight of the medication by the worker requires teamwork, including coordination and communication amongst caregivers, service providers, parents, medical/mental health providers and, when appropriate, the child. HHS encourages parental involvement in decision-making to the greatest extent possible. When the worker receives the medication report, they are to verify that it is accurate and reflects the current medications of the child. The worker documents in the case narrative if the medication is working well, if there are any side effects, or if the child or others report concerns about the medication. Workers may also consult the child's physician, pharmacist, or the National Institutes of Health's Drug Information website. In addition, if appropriate, the worker advocates on the child's behalf to have the medications reviewed by the physician and explore alternatives. The worker places the medication report in the case file and any corresponding case management activities documented in the visitation notes or contact notes.

These quarterly psychotropic medication reports along with the Drug Utilization Review (DUR) Commission letters to providers contributed to the lowering of the usage of psychotropic medication. The DUR Commission examines the use of multiple antipsychotics and sends notification letters to prescribers and pharmacies stating they identified a member as having a drug related issue and makes a suggestion regarding medication therapy. Currently, based upon 6 months of pharmacy claims data, the DUR Commission sends the provider notification letters only to Medicaid fee-for-service providers. The DUR Commission sends these letters to providers that meet a certain set of criteria, either through regular profile reviews (which consist of 1,800 profiles over a 12 month period) or a targeted intervention (specific population, member count varies). The DUR does not send letters to **all** prescribers who prescribe two or more psychotropic agents simultaneously. Additionally, the DUR reviews 300 member (of all ages) profiles identified with the highest level of risk for a drug related issue at each meeting; a small portion is for children for whom not all are on psychotropic medications.

Shared Decision-Making (Informed Consent and Assent)

HHS is reviewing policy, practice, and procedure around informed consent and assent for the prescribing of psychotropic medications for children and youth in foster care. A workgroup has been formed on the Psychotropic Medication Advisory Committee. One of the objectives for this workgroup was developing a consent for psychotropic medication form to document diagnosis, proposed medication, expected benefits, possible risks/side effects, red flag information, and alternate treatment options. Signatures on the proposed form would indicate that review of the above information occurred with and consent obtained from the parent or legal guardian as well as assent obtained from the youth. A draft Informed Consent/Assent form has been developed by the committee and has been sent out to internal and external stakeholders for feedback. The form is expected to be finalized this summer.

Response to U.S. Health and Human Services, Office of Inspector General (OIG) Report

Stakeholder Workgroup: Upon completion of a comprehensive review of policy, practice, and procedure over the course of the fall of 2019 and spring of 2020, it was determined that data would play a key role in guiding the work of the stakeholder workgroup. Efforts started at that time to build out data sharing processes with Iowa Medicaid Enterprise (IME). The Pandemic has placed considerable additional workload on IME and their systems. As a result, significant delay of the data sharing efforts occurred, and the stakeholder workgroup did not convene in 2020.

However, an internal stakeholder group that included members of Child Welfare Policy, Child Welfare Field, IME, Mental Health and Disability Services (MHDS), and the Attorney General's Office met in April

of 2021. This group reviewed information from the OIG report, the requirements in the Health Care Oversight and Coordination Plan specific to psychotropic medication, and the AACAP guidelines for monitoring psychotropic medications for children and youth in foster care. This internal stakeholder group was able to identify members for a Psychotropic Medication Advisory Committee. This advisory committee is compromised of internal and external stakeholders, including a child psychiatrist, pharmacy directors, medical directors, other experts in health care, and experts in and recipients of child welfare services. The advisory committee will provide policy and practice recommendations to provide consistent oversight of psychotropic medication for children and youth in foster care and throughout the state. Dawn Kekstadt, Bureau Chief of Child Welfare and Community Services is leading the group. Three subgroups have been formed which include a Youth/Parent Rights Group, an Informed Consent group, and a Data group. Iowa Total Care has taken the lead with getting data. Some of the goals of the committee are to:

- Build out a clearly delineated process for the monitoring and oversight of psychotropic medications for children and youth in foster care to ensure they are prescribed and utilized appropriately, safely, and effectively.
- Ensure that HHS Child Welfare policy and practice are aligned with the AACAP best practice guidelines for the oversight of psychotropic medication for children and youth in foster care.
- Build out a collaborative cross-systems approach to oversight of psychotropic medications for children and youth in foster to maximize resource and improve outcomes.
- Ensure the consistent implementation of psychotropic medication oversight policies across the state.

The Informed Consent group developed a draft Psychotropic Medication Informed Consent/Assent form which is currently being reviewed by internal and external stakeholders for feedback. This group also developed a Psychotropic Medication One Pager which highlights key information for kin caregivers and foster parents on psychotropic medications and youth in foster care. This document is also being reviewed for feedback. The Youth/Parent Rights group has been working on an initial draft for a Youth/Parent rights document. The Data group has run into system issues and has not been able to access accurate data.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

All children in foster care enrolled in Medicaid are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Iowa has an EPSDT Care for Kids stakeholder workgroup comprising representatives from IME, Iowa Department of Public Health, managed care organizations (MCOs), and the University of Iowa. This workgroup focuses on the benefits, coverage, and education around the EPSDT for all Medicaid children.

The IME completes the required annual EPSDT Participation Report that reflects all eligible participants. However, the Report does not delineate the foster care population. The last annual EPSDT report was for fiscal year 2017. This report shows all eligible individuals for EPSDT, the state periodicity schedule, age groups, the expected number of screenings per eligible and total screenings received, categorized into two eligibility groups of Categorically Needy (CN) and Medically Needy (MN).

HHS child welfare staff are also working with IME to pull out of the Core Set of Children's Health Care Quality Measures for the foster care population. Child welfare staff will utilize the child core set to assist us in monitoring the physical health, behavioral/mental health, and dental health care of children in foster care. IME recently upgraded its information system allowing for information specifically on the foster

care population separate from the general Medicaid population. Core set data and reporting is managed by an outside contractor for IME. IME added pulling core set data for children and youth in foster care to their SFY 2022 contract and has indicated that they will provide data for CY2018-CY2019 by August 6, 2021. CY2020 will be provided by December 31, 2021. Ongoing reports will be provided on a yearly basis by December 31st of each year.

HHS did not obtain the Core Set data for the following reasons- too many systems issues and concerns with being able to identify unlicensed placements. It is hoped that HHS will obtain better data as we implement the new CCWIS system. However, HHS continues to evaluate how to better partner with Medicaid around health care outcomes for children and youth in foster care. This is especially true as HHS works through the alignment process. HHS is exploring case management options and are having the workers assist the MCOs with completion of the Health Risk Assessments for our shared members. HHS has decided to stop pursuing this until our new CCWIS system has been implemented. This new system will be connected to Medicaid.

Workforce

The 2019 legislative session approved additional funds to hire more child protective workers (CPWs) and SWCMs. In SFY 2021, CPW's had an average caseload of 16 cases and SWCM's had an average caseload of 25. HHS hopes that these caseload numbers will stabilize for SWCM's thereby enabling them to complete treatment plans for all children in foster care and to monitor better their medications and their physical and mental health at their monthly visits with the children.

In October of 2020, HHS published an updated employee manual. The employee manual combined policy, practice, and procedures into one program manual to eliminate duplication. Additionally, it included revisions to policy, practice, and procedure since the last published updates. The case management manual includes new sections on monitoring medications of children in foster care as well as new information about Parent Partners, family-centered services (FCS), and kinship support that were not previously published in the manual. HHS continues to update the employee manual to ensure the most up to date information is available.

How Iowa actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

HHS SWCMs assess the physical, dental, and mental health, and substance abuse needs, if applicable, of children in foster care. SWCMs consult with physicians or other appropriate medical or non-medical professionals for initial and ongoing medical exams, mental health evaluations, substance abuse evaluations, and necessary follow-up treatment, if determined needed by the health professional. HHS SWCMs also participate in joint treatment planning conferences (JTPC) with HHS field operations support unit (FOSU) staff, HHS Mental Health and Disability Services (MHDS) staff, and medical professionals to discuss complex cases in an effort to ensure that children in foster care receive the most appropriate services for their needs. SWCMs submit a request for a JTPC, which includes the following information in the request:

- Name of child
- State ID
- Date of birth

- Summary of the child's current situation and the purpose of the call. (Please keep in mind that the calls are not intended to discuss funding issues, level of care decisions, etc. The call's focus is on the need for case management and assistance in setting up services to support the child and family.)
- List of names, phone numbers, and email for each of the individuals invited to the call.

The SWCM sends the request directly to the MCO. A dedicated staff person located in the Bureau of Service Support and Training offers to sit on the calls. Some of the common reasons for calls are questions about waiver programs and youth eligibility, hard to place youth and needed placements, and services for youth in and out of the home.

Outline the procedures and protocols the State established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.

When children placed in foster care come into the child welfare system, SWCMs look for the nearest care provider in order to continue their medical home and their existing treatment plans. HHS staff completed and submitted pre-file language for the Iowa 2019 legislative session, to include in the child's case plan documentation of:

- Efforts to retain professional providers for children entering/in foster care and
- Activities to evaluate service needs in order to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities.

The 2019 legislative session resulted in amending Iowa Code § 232.2, Definition of "case permanency plan" to add plans for retaining any suitable existing medical, dental, or mental health care providers of the child when the child enters foster care. House File 644 also required HHS to amend its administrative rules. The administrative rules provide that a case permanency plan for a child placed in foster care shall include information describing efforts to maintain suitable mental health care and medical health care for the child to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities. In January 2020, HHS submitted an amendment to IAC 441-202.1(234) to add the following language to the definition of case permanency plan:

> *"this includes information describing efforts to retain existing medical and mental health care providers for a child entering foster care and activities to evaluate service needs to avoid inappropriate diagnosis of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities."*

The Iowa Administrative Rules Review Committee adjusted its work in response to the Coronavirus pandemic, which delayed enactment of the administrative rule change. This rule was enacted effective 1/1/21. Prior to the enactment of this this rule, HHS added an emphasis on keeping children with their current health care providers to mitigate misdiagnosis to the case plan in conjunction with the changes made to the case plan for transition planning noted below. For example, HHS added the following question on the Health records section of the Records tab:

- "Was the child able to maintain current health care provider (mental, physical, dental)?"
    - "If no, describe efforts made to maintain continuity of care":

HHS and Iowa Medicaid Enterprise (IME) are currently working together to contract with the University of Iowa to complete Complex Youth Care Assessments. The University of Iowa will be providing specialty medical services for complex youth under the care of HHS. There is a workgroup talking through this process which is expected to begin in July 2023. Some of the reasons for an assessment referral may include:

- Unclear health status in the setting of neglect or abuse
- Mood or anxiety symptoms
- Disruptive behavior symptoms
- Unusual/odd behaviors present over time (not on an isolated basis)
- Problems with eating/growth
- Concerns for harm to self or harm to others on a chronic basis, not including acute needs
- Poor adaptation to living situation changes occurring during HHS involvement
- Poor academic or behavioral performance

Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.

Iowa utilizes the streamlined procedure for youth automatically continuing on Medicaid; used previously for the Medicaid for Independent Young Adults (MIYA) program (reviewing first for any other Medicaid coverage groups the youth may be eligible for), once their foster care case closes. Extended Medicaid for Independent Young Adults (E-MIYA) uses a passive annual review to ensure location of the participant and any changes in household, which may make the participant eligible for other Medicaid coverage groups rather than E-MIYA.

The HHS transition planning specialists train workers on educating youth on the review procedure prior to discharge from care. Additionally, Aftercare workers and foster families received information on the procedure to assist those youth on their caseload with the review process. HHS stresses the reapplication process in new worker training. Youth automatically placed on E-MIYA or any other type of Medicaid coverage group at the point of discharge receive a letter from HHS explaining the Medicaid coverage and the renewal process. Staff are trained to tell youth to contact HHS or the Iowa Aftercare Services provider if they receive paperwork they need help with after discharge.

In 2017, the Service Business Team (SBT), as planned, developed a written charter that identified goals, objectives and membership of a workgroup to evaluate and make recommendations for necessary and desired enhancements to the Transition Plan sections of the case permanency plan.

A workgroup (12 members) convened in early 2018. The workgroup capitalized on combined experience from child welfare policy, field social work, information systems, and juvenile justice. Information technology (IT) experts explained how and if desired changes may occur to the information systems. Supervisors and caseworkers attended. A foster care alumni representative captivated the team with her story. She was a great resource for the team, particularly during discussions about the real impacts and perceptions of case planning.

The workgroup completed their recommendations in March 2018. They successfully explored format changes and highlighted errors. They made recommendations for training structure and training content needed to implement changes. The workgroup facilitator captured the notes and formal recommendations of the workgroup, and then sent them to SBT for review and decision-making. SBT approved the changes recommended.

Because of that workgroup's recommendation, a Transition Planning Tab became active in the Child Placement Plan (Part C of the case permanency plan) on February 25, 2020. A webinar occurred on January 14, 2020 to provide SWCMs and supervisors with training on the changes. The webinar remains on the HHS training website.

The health care needs of youth aging out of foster care were one of the five priority areas identified and improved for the new transition plan, including the requirements to include options for health insurance, information about a health care power of attorney, and a health care proxy.

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Appendix A - Psychotropic Medication Report

You are receiving the attached report because one or more of your clients in out-of-home care:

1. Has been prescribed two or more psychotropic medications and/or
2. Is under the age of 6 and receiving at least one psychotropic medication

HHS has the responsibility to ensure the mental health needs of children in out-of-home care are met, including the oversight of medication prescribed for mental health. Appropriate oversight includes, but is not limited to:

- Ensuring that a child is seen regularly by a physician to monitor the effectiveness of the medication, assess any side effects and/or health implications, consider any changes needed to dosage or medication type, and determine whether medication is still necessary and/or if other treatment options would be more appropriate.
- Regularly following up with foster parents/caregivers about administering medications appropriately and about the child's experience with the medications(s), including any side effects.

Given increasing research regarding potential negative side effects of prescribing multiple psychotropic medications concurrently or for very young children, oversight is critical. Providing appropriate oversight of medication at the HHS worker level requires teamwork, including coordination and communication amongst HHS, caregivers, service providers, parents, medical/mental health providers, and when appropriate, the child. Parental involvement and decision-making should be encouraged to the greatest extent possible.

You are being asked to verify that the attached report accurately reflects the medications the child is currently taking. If the report is accurate:

- Does everything appear to be going well (e.g., are there adverse side effects, etc.)? Does the child or others report concerns about the medications?
- If you have questions regarding the medication and possible side effects, consult the child's physician, pharmacist, or the National Institutes of Health's Drug Information Website at **U.S. National Library of Medicine**.
- If appropriate, advocate on the child's behalf to have the medications reviewed by the physician and explore alternatives.
- Ensure the child's parents are aware.

Place the attached medication report in the case file and document any corresponding case management activities in Visitation Notes (under the Child Well-Being section) or Contact Notes.

If you have any questions, please contact the **Service Help Desk**.

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Appendix B – Psychotropic Medication Advisory Committee Charter

SCOPE

Guided by the American Academy of Child and Adolescent Psychiatry (AACAP) best practice, the Psychotropic Medication Advisory Committee is a collaboration between state agencies, community providers, and youth and families served by the child welfare foster care system. This committee will provide policy and practice recommendations to provide consistent oversight of psychotropic medication for children and youth in foster care throughout the state.

The efforts focus on three components: 1) program development 2) policy and practice: development, refinement, implementation, and education, and 3) outcomes and results-based accountability: data development and continuous quality improvement.

GOALS

1. Build out a clearly delineated process for the monitoring and oversight of psychotropic medications for children and youth in foster care to ensure they are prescribed and utilized appropriately, safely, and effectively.
2. Ensure that HHS Child Welfare policy and practice are aligned with the AACAP best practice guidelines for the oversight of psychotropic medication for children and youth in foster care.
3. Build out a collaborative cross-systems approach to oversight of psychotropic medications for children and youth in foster care to maximize resources and improve outcomes.
4. Ensure the consistent implementation of psychotropic medication oversight policies across the state.

OBJECTIVES

1. Develop a process for informed and shared decision-making (consent and assent).
2. Develop protocols for the appropriate use and monitoring of psychotropic medications at both the agency and individual case level.
3. Develop a process for access to mental health expertise and consultation regarding consent and monitoring issues at both the agency and individual case level.
4. Develop a process for comprehensive and coordinated screening, assessment, and treatment planning for children/youth's mental health and trauma needs. This includes identifying methods for ongoing communication between treatment team members and steps to ensure continuity of services.
5. Develop mechanisms for sharing accurate up-to-date information regarding psychotropic medications and educational materials to child welfare staff and consumers.
6. Identify procedures and protocols to ensure children/youth in care are not inappropriately diagnosed and placed in settings that are not foster family homes as a result of the inappropriate diagnosis.

NON-NEGOTIABLES

1. Align Iowa's practice and policy with guidelines from the American Academy of Child and Adolescent Psychiatry (AACAP).
2. Recommended policy, practice, and processes will follow the framework of the Child and Family Services Plan: Health Care Oversight and Coordination Plan.

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ADVISORY COMMITTEE MEMBERS

Name	Organization	Position/Role	Field of Expertise
Dr. Hannah Stevens	University of Iowa Health Care	Child Psychiatrist	Behavioral Health
Rebecca Curtiss	Iowa Medicaid Enterprise	Bureau Chief for Quality and Innovation	Behavioral Health
Lisa Todd	Amerigroup	Pharmacy Director	Pharmaceuticals
Emily Rogers	Iowa Total Care	Pharmacy Director	Pharmaceuticals
Dr. Deborah Garrelts-Daoud	Iowa Total Care	Behavioral Health Medical Director	Behavioral Health
Dr. William Jagiello	Iowa Medicaid Enterprise	Medical Director	Medical Health
Dawn Kekstadt	HHS CWCS	Bureau Chief	Child Welfare
Elizabeth "Libby" Lucken		Parent for Family Voice	Child Welfare
Gabriella Ferring		Youth Voice	Child Welfare
Tiara Mosley		Youth Voice	Child Welfare
Meghan Anderson		Youth Voice	Child Welfare
Jarek Vetter		Foster Parent	Child Welfare
Ellen Ramsey Kacena	Office of the Attorney General	Assistant Attorney General	Child Welfare
Hannah Olson	Iowa Medicaid Enterprise	Mental Health and Substance Use Disorders Program Manager	Behavioral Health
Linda Dettmann	HHS CWCS	Case Management Program Manager	Child Welfare
Else Umbreit	Iowa Medicaid Enterprise	QIO	Pharmaceuticals
Kathy Thompson	Children's Justice	Executive Director	Child Welfare