Implementation of Psychotropic Medication Monitoring:

Best Practice Model for Child Welfare in Fairfax County

April 19, 2017
CSA State Conference

History

- In 2010, a Psychotropic Medication workgroup was formed out of concern about overmedication of youth in foster care based on national research.
- The group consisted of managers, supervisors, and social workers in the foster care program.
- Based on their research and benchmarking, the group developed a draft best practice model.

History cont'd.

- The group's finding was that psychotropic medications were over-prescribed for children in foster care often as a result of un-resolved/un-treated trauma.
- A CSA system of care initiative occurring at around that time was also looking at Trauma-Informed and Evidence-based Practices.
- The child welfare and CSA groups joined to look at how to implement/infuse Trauma-Informed Practice along with medication monitoring for child welfare staff and CSA partner agencies.

Implementation Planning

- Workgroup wanted baseline data
  - Our information systems do not allow for extraction of medication data
  - Medication data is not currently entered
  - Conducted a poll of foster care staff for estimated med usage
  - 101/337 (30%) youth in care were using medication
- Workgroup identified data as a major challenge

Implementation Planning

- Regional focus groups to assess current practice regarding psychotropic medication use across child welfare programs
  - CPS referrals related to med non-compliance
  - However, parents were not educated about medication
  - Practice issues differ for foster care staff vs. CPS and voluntary cases
  - Power differential between prescriber and parent/custodian

Implementation Planning

- Conclusions:
  - All child welfare programs could benefit
  - Staff strongly supported the need for more information and support around medication monitoring
  - Child welfare program-wide implementation not recommended
  - Determined that a smaller pilot program would allow for greater likelihood of success

Leadership Support

- The best practice model was presented and approved by Child Welfare leadership to include:
  - Agency Director, Division Director
  - CPS Intake, On-going CPS, Foster Care and Adoption, Prevention, Family Engagement/ Kinship/Fatherhood
  - Quality Assurance
- All the child welfare programs adopted the model and approved a pilot implementation.

The Pilot

- **Who?**
- 1 or 2 supervisors in each program to pilot
- Then, the supervisor will identify 2 or 3 volunteers from the unit
- Each volunteer will pilot in 2-3 cases in his/her caseload
- Attend a short orientation

- **For How long?**
- Pilot for a year from 2/10/2015-2/28/2016

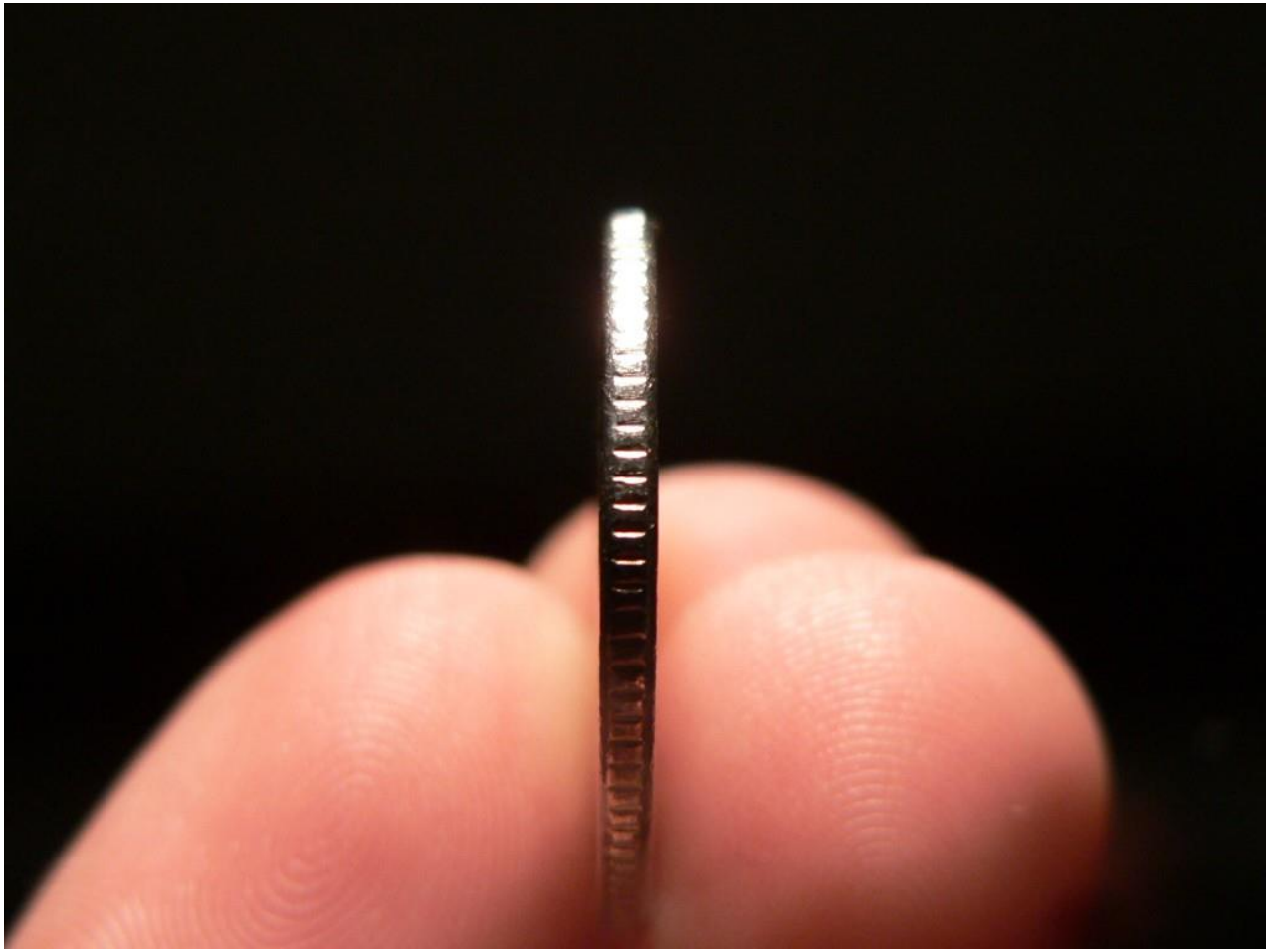
- **Who can also provide support?**
- Psychiatric Medication workgroup members for consultation
- Quarterly review/support/update meeting with Psy. Meds. Subgroup

- **Then what?**
- Plan to review implementation with pilot groups and to develop policy/guidance after a year

Link to Other Best Practices

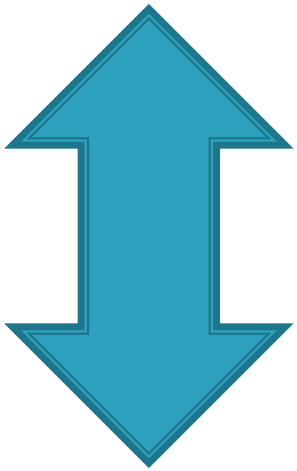
- Trauma-informed Practice
  - System-wide training
  - Assessment/Screening tool (in progress)
- Permanency Initiative
  - VDSS For Keeps Initiative
  - Annie E. Casey Agents of Change
- Family Engagement
  - Family Partnership Program
  - Kinship Unit
  - Fatherhood Initiative
- Partnership with CSA System of Care
  - Private provider community
  - Cross-agency work on Trauma-Informed Care

Trauma and Overuse of Psychotropic Medications



What We Believe

Lack of Trauma-Informed Practice



Over-use of Psychotropic Medications

Trauma-Informed Practice

- Steering Committee
  - Screening Tools workgroup
  - Training workgroup
  - Agency policy and procedures (planned)
- NCTSN Child Welfare Toolkit Training
  - Staff position for state-sponsored "Train the Trainer" conference
- Agency-wide Trauma Initiative Kick-Off (by Allison Sampson Jackson)
- Linkage to cross-agency trauma initiative

Trauma-informed Care: Appropriate Assessments and Effective Interventions

- Appropriate assessment and diagnosis including history of trauma exposure
- Sharing assessment and diagnosis with all treatment providers to avoid fragmented care
  - Children change providers and information is lost
- Trauma-specific treatment
  - Referrals to providers who offer specialized treatment services

Best Practice Model for Monitoring Psychotropic Medications

- Fairfax County Child Welfare

Best Practice Model

- Training and Information
- Assessment
- Treatment and Interventions
- Informed Consent
- Monitoring tools
- Psychiatric Consultation
- Outcomes

Training and Resources

- Partnered with Magellan to offer an all-staff training for 3 hours on psychotropic medication
- Videotaped the Magellan training to create an ongoing training resource
- Provided staff in pilot with the following resources:
  - Psychotropic Medication Best Practice Tool for CYF workers and supervisors
  - "Making Healthy Choices – A Guide on Psychotropic Medications for Youth in Foster Care"
  - "Facts for Families", Part 1 -3
  - Tips for Practice – Psychotropic Medication

Monitoring Tool

- Created a 2 page form to guide best practice
- Form created by workgroup and then received feedback from several psychiatrists (Magellan Learning Collaborative)
- Not required for staff to complete at this time
- Currently being used in the pilot project

Screening and Assessment

- Subgroup working to identify a screening tool for child welfare staff to utilize
- Youth in system have existing assessments that should be provided to treating physician
- Best practice: Physician should have access to diagnostic assessment(s) that provide relevant background information and treatment history

Best Practice Tool: Assessment and Examination

ASSESSMENT & EXAMINATION			**If <u>No</u> to any question(s) below, please explain**:
Is there a diagnostic assessment(s) to support prescribed psychotropic medication?	Yes	No	
Prior to the assessment, was the prescribing physician provided with the following? [Check all that apply]			
Birth and developmental history Psychiatric history (including prior psychiatric medications and their effects Mental health history of birth family History of trauma for the child Family circumstances and social history	Medical history and results of any physical examinations, laboratory, allergies, or other tests (including all current prescribed or OTC medications, and/or herbal preparations) DSM diagnosis Mental status examination Estimated intelligence and cognitive functioning Prenatal exposure to drugs/alcohol	Cultural and spiritual issues Placement history Substance use Legal issues/status Education progress & needs Any/all treatment plan(s) Strengths	
If relevant item(s) above is missing, please follow up to provide.		***Follow Up Date*: _____**	
Is lab work required?	Yes _____ Date Completed	No	

Treatment and Interventions

- Is there a medication treatment plan that is integrated with the other treatments and services being provided?
- Medication alone is rarely sufficient to meet the needs of the child.
- Service planning should include a range of treatments and interventions to meet the identified needs of the youth. (e.g., TF-CBT, ABA, DBT)

Best Practice Tool: Treatment & Interventions

TREATMENT & INTERVENTIONS			
Is there a medication treatment plan?	Yes	No	

Does the medication treatment plan include the following? (Check all that apply)

Dosage (how much) Medication purpose Medication review(s) Medication discontinuation plan (if applicable)

Please check <u>all</u> interventions/therapies that are being used.

Cognitive Behavioral Mode Deactivation Art/Expressive Play-based Parenting

Applied Behavioral Analysis Dialectical Behavior Animal-Assisted Psychodynamic

Other (please specify) _____

Which of the following are being used for interventions/therapies identified above? Check all that apply.

Modality			*Setting*		
Individual	Family	Group	Outpatient	Home Based	GH/RTC

What is/are the focus/foci of the interventions/therapies being used? Check all that apply.

Trauma Attachment Behavior Management Anger Management Social Skills

Parenting Skills Substance Abuse Sexual Reactivity/Offending

Other (please specify) _____

Informed Consent

- Family and Youth Engagement
  - Have birth and foster families been educated about the recommended medications?
  - Have they had a chance to ask questions and receive appropriate information?
  - Has the youth been part of the decision making process regarding recommended medications?
  - Has the youth had a chance to ask questions and understand options?
  - Does the youth have a voice in the decision-making about treatment options?

Best Practice Tool: Informed Consent

INFORMED CONSENT			
Prior to administration of psychotropic medication, did the youth receive the *Making Healthy Choices* Guide?	Yes	No	
Prior to administration of psychotropic medication, were the following individuals informed?	Mother Father Caregiver Guardian Child Welfare Worker TFC Case Manager		

Worker: _____
Signature

_____
Print Name

Date Completed: _____

Supervisor: _____
Signature

Psychiatric Consultation

- Best practice requires monitoring of medications and follow up when needed
- When certain circumstances arise, consultation by another physician may be warranted:
  - Prescribing medication with potentially adverse side effects (metabolic syndrome)
  - Child/youth less than 6 years old
  - Taking 3 or more psychotropic medications at the same time

Best Practice Tool: Consultation

SITUATIONS IN WHICH A PSYCHIATRIC CONSULT MAY BE REQUESTED
Do any of the following situations apply to this child/youth? [check all that apply]
Absence of thorough assessment or DSM diagnosis in child's medical and/or foster care record
Taking three or more medications at the same time
Taking two or more medications for the same purpose
Prescribing more than one medication for a symptom before trying a single medication
Medication dose exceeds usual recommended dose
Prescribing medication that have adverse side effects*****
Prescribing medication that is not FDA approved for children
Prescriptions by primary care provider with no documented specialty training for diagnosis other than attention deficit hyperactive disorder (ADHD) or uncomplicated anxiety disorder
Absence of goal to transition child/youth off medication in the medication treatment plan
Child/youth is less than six years old
Others:_____
*******Medications with adverse side effects may include those with the potential to induce or increase the child/youth's risk for: suicidal thoughts, raised cholesterol level, weight gain, diabetes, tardive dyskinesia, sun sensitivity/dehydration, etc.*

If any of the situation(s) described in the Table above apply to this child/youth, a psychiatric consult may be requested.

_____
Date of Consult

Anticipated Outcomes

- Purpose of the pilot and monitoring of medications
  - Families and Youth more involved in the treatment planning and decision making
  - More effective treatment planning (trauma-specific treatment)
  - Improved well-being indicators
  - Reduction in medication use
  - Shorter duration of medication use

Learning Collaborative Approach

- Quarterly Meeting of Pilot Group
  - Sharing of experiences using the best practice tool
    - Using the tool when youth stepping down from RTC
    - Meds discontinued for two youth; foster parents advocated and adjusted home environment
  - Problem-solving about barriers and challenges
    - Lack of Medicaid provider, provider changes
    - Response of provider when questioned
    - Physician not having complete information
    - Differences of opinion about medication between caregiver and non-resident parent
    - Working with school personnel around attitudes toward medication for behavior management

Learning Collaborative

- Monthly emails to the pilot group to stay in touch, share resources
- Quarterly face to face meetings of the pilot group
- Survey of participants at 6 months for feedback on the tools and data tracking
- Used DFS Admin staff (QA) to support the effort, analyze data

Challenges

- Staff and leadership turnover delayed implementation
- Time, commitment and sustaining the effort
- Lack of medication data
- Options for psychiatric consults
- Competing priorities for staff and training resources
- System changes (e.g. Administrative, budget, communication, change management, info management, leadership, public policy, partnerships, strategies, technology, workforce)

Outstanding Questions:

- How can specialists get second opinions/consultation on cases with red flags? Who can do it and how can we pay for it? Can we partner with Magellan to help with this?

- How can we access a comprehensive data set on medication use among our foster care and non-foster care populations?

Outstanding Questions:

- How can specialists and therapists on our cases develop better partnerships with psychiatrists?
- What is happening at the Virginia state level in terms of policy development and medication management programs?

Pilot Conclusions

- Develop guidelines for entering medication information into OASIS.
- Incorporate a psychotropic drug training into the training provided to new foster parents so they can be the best advocates possible.

Pilot Conclusions

- Develop a list of preferred providers- psychiatrists and therapists who are trauma-informed and accept Medicaid or Anthem.
- Determine if it is possible and under what circumstances children can have longer medical appointments when discussing medication management.
- Partner with schools to educate about psychotropic medications.
- Determine how to make sure whoever is going with the child on a medical visit for psychotropic medication management is able to ask questions about the decisions being made and is able to answer questions about the child's medical history. Ideally, this would be someone who has gone through psychotropic medication training.

Pilot Conclusions:

- Implement CYF staff trainings on psychotropic medications as well as on how to effectively communicate with psychiatrists. Finding a way to minimize the time requirements is necessary due to the numerous demands on specialists.
- Start conversations with state representatives to determine what initiatives are happening at the state level and what potential partnerships could be made to give us more traction/resources.
- Infuse psychotropic medication tools used in this pilot into everyday practice in CYF (encourage their use with families, at case staffings, at supervision, etc.).

Questions, comments

- Thank you!

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