Children's Commission

SUPREME COURT OF TEXAS PERMANENT JUDICIAL COMMISSION FOR CHILDREN, YOUTH AND FAMILIES

HB915 Implementation Workgroup

Tuesday, July 23, 2013

Hatton Sumners Room
State Bar of Texas
Texas Law center
1414 Colorado Street
Austin, TX 78701

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Hatton Sumners Room
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1414 Colorado Street
Austin, Texas 78701

Tuesday, July 23, 2013
9:30 am – 12:30 pm

9:30 a.m. Convening and Introductions – Judge Scott McCown

10:00 a.m. Update on DFPS Implementation – Liz Kromrei and DFPS Team

- **SECTION 1 – New Guardian Ad Litem Duties**
- **SECTION 2 – New Attorney Ad Litem Duties**
- **SECTION 3 – Adds definitions of Advanced Practice Nurse and Physician Assistant**
- **SECTION 4 – Permanency Hearings**
- **SECTION 5 – Placement Review Hearings**
- **SECTION 6 – Transition Plan**
- **SECTION 7 - Adds definitions of Advanced Practice Nurse**
- **SECTION 8 - Medical Consenter Training**
- **SECTION 9 – Requirement for Informed Consent Before Prescribing Psychotropic Medications**
- **SECTIONS 10, 11 – Notify Parents of Psychotropic Medication**
- **SECTION 12 – Judicial Review of Medical Care**
- **SECTION 13 - Monitoring Use of Psychotropic Medications at Least Every 90 Days**
- **SECTION 14 – Monitoring New Populations of Children**

10:30 a.m. Facilitated Discussion Regarding Informed Consent – Judge McCown

12:15 p.m. Ongoing Collaboration

Final plan by August 31, 2013, including recommendations regarding the need for reauthorization or changes to the structure or membership of the Implementation Workgroup.

- Future Meetings - August 27, 2013

12:30 p.m. Adjourn

AN ACT

relating to the administration and monitoring of health care provided to foster children.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 107.002, Family Code, is amended by adding Subsection (b-1) to read as follows:

(b-1) In addition to the duties required by Subsection (b), a guardian ad litem appointed for a child in a proceeding under Chapter 262 or 263 shall:

(1) review the medical care provided to the child; and

(2) in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided.

SECTION 2. Section 107.003, Family Code, is amended to read as follows:

Sec. 107.003. POWERS AND DUTIES OF ATTORNEY AD LITEM FOR CHILD AND AMICUS ATTORNEY. (a) An attorney ad litem appointed to represent a child or an amicus attorney appointed to assist the court:

(1) shall:

(A) subject to Rules 4.02, 4.03, and 4.04, Texas Disciplinary Rules of Professional Conduct, and within a reasonable time after the appointment, interview:

(i) the child in a developmentally appropriate manner, if the child is four years of age or older;

(ii) each person who has significant knowledge of the child's history and condition, including any foster parent of the child; and

(iii) the parties to the suit;

(B) seek to elicit in a developmentally appropriate manner the child's expressed objectives of representation;

(C) consider the impact on the child in formulating the attorney's presentation of the child's expressed objectives of representation to the court;

(D) investigate the facts of the case to the extent the attorney considers appropriate;

(E) obtain and review copies of relevant records relating to the child as provided by Section 107.006;

(F) participate in the conduct of the litigation to the same extent as an attorney for a party;

(G) take any action consistent with the child's interests that the attorney considers necessary to expedite the proceedings;

(H) encourage settlement and the use of alternative forms of dispute resolution; and

(I) review and sign, or decline to sign, a proposed or agreed order affecting the child;

(2) must be trained in child advocacy or have experience determined by the court to be equivalent to that training; and

(3) is entitled to:

(A) request clarification from the court if the role of the attorney is ambiguous;

(B) request a hearing or trial on the merits;

(C) consent or refuse to consent to an interview of the child by another attorney;

(D) receive a copy of each pleading or other paper filed with the court;

(E) receive notice of each hearing in the suit;

(F) participate in any case staffing concerning the child conducted by an authorized agency; and

(G) attend all legal proceedings in the suit.

(b) In addition to the duties required by Subsection (a), an attorney ad litem appointed for a child in a proceeding under Chapter 262 or 263 shall:

(1) review the medical care provided to the child;

(2) in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided; and

(3) for a child at least 16 years of age, advise the child of the child's right to request the court to authorize the child to consent to the child's own medical care under Section 266.010.

SECTION 3. Section 263.001, Family Code, is amended by amending Subdivision (1) and adding Subdivisions (1-a) and (3-a) to read as follows:

(1) "Advanced practice nurse" has the meaning assigned by Section 157.051, Occupations Code.

(1-a) "Department" means the Department of Family and

Protective Services.

(3-a) "Physician assistant" has the meaning assigned by Section 157.051, Occupations Code.

SECTION 4. Section 263.306(a), Family Code, is amended to read as follows:

(a) At each permanency hearing the court shall:

(1) identify all persons or parties present at the hearing or those given notice but failing to appear;

(2) review the efforts of the department or another agency in:

(A) attempting to locate all necessary persons;

(B) requesting service of citation; and

(C) obtaining the assistance of a parent in providing information necessary to locate an absent parent, alleged father, or relative of the child;

(3) review the efforts of each custodial parent, alleged father, or relative of the child before the court in providing information necessary to locate another absent parent, alleged father, or relative of the child;

(4) return the child to the parent or parents if the child's parent or parents are willing and able to provide the child with a safe environment and the return of the child is in the child's best interest;

(5) place the child with a person or entity, other than a parent, entitled to service under Chapter 102 if the person or entity is willing and able to provide the child with a safe environment and the placement of the child is in the child's best

interest;

(6) evaluate the department's efforts to identify relatives who could provide the child with a safe environment, if the child is not returned to a parent or another person or entity entitled to service under Chapter 102;

(7) evaluate the parties' compliance with temporary orders and the service plan;

(8) review the medical care provided to the child as required by Section 266.007;

(9) ensure the child has been provided the opportunity, in a developmentally appropriate manner, to express the child's opinion on the medical care provided;

(10) for a child receiving psychotropic medication, determine whether the child:

(A) has been provided appropriate psychosocial therapies, behavior strategies, and other non-pharmacological interventions; and

(B) has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days for purposes of the review required by Section 266.011;

(11) determine whether:

(A) the child continues to need substitute care;

(B) the child's current placement is appropriate for meeting the child's needs, including with respect to a child who has been placed outside of the state, whether that placement continues to be in the best interest of the child; and

(C) other plans or services are needed to meet

the child's special needs or circumstances;

(12) [~~(9)~~] if the child is placed in institutional care, determine whether efforts have been made to ensure placement of the child in the least restrictive environment consistent with the best interest and special needs of the child;

(13) [~~(10)~~] if the child is 16 years of age or older, order services that are needed to assist the child in making the transition from substitute care to independent living if the services are available in the community;

(14) [~~(11)~~] determine plans, services, and further temporary orders necessary to ensure that a final order is rendered before the date for dismissal of the suit under this chapter;

(15) [~~(12)~~] if the child is committed to the Texas Juvenile Justice Department [~~Youth Commission~~] or released under supervision by the Texas Juvenile Justice Department [~~Youth Commission~~], determine whether the child's needs for treatment, rehabilitation, and education are being met; and

(16) [~~(13)~~] determine the date for dismissal of the suit under this chapter and give notice in open court to all parties of:

(A) the dismissal date;

(B) the date of the next permanency hearing; and

(C) the date the suit is set for trial.

SECTION 5. Section 263.503(a), Family Code, is amended to read as follows:

(a) At each placement review hearing, the court shall determine whether:

(1) the child's current placement is necessary, safe, and appropriate for meeting the child's needs, including with respect to a child placed outside of the state, whether the placement continues to be appropriate and in the best interest of the child;

(2) efforts have been made to ensure placement of the child in the least restrictive environment consistent with the best interest and special needs of the child if the child is placed in institutional care;

(3) the services that are needed to assist a child who is at least 16 years of age in making the transition from substitute care to independent living are available in the community;

(4) the child is receiving appropriate medical care;

(5) the child has been provided the opportunity, in a developmentally appropriate manner, to express the child's opinion on the medical care provided;

(6) a child who is receiving psychotropic medication:

(A) has been provided appropriate psychosocial therapies, behavior strategies, and other non-pharmacological interventions; and

(B) has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days for purposes of the review required by Section 266.011;

(7) other plans or services are needed to meet the child's special needs or circumstances;

(8) [~~(5)~~] the department or authorized agency has exercised due diligence in attempting to place the child for

adoption if parental rights to the child have been terminated and the child is eligible for adoption;

(9) [~~(6)~~] for a child for whom the department has been named managing conservator in a final order that does not include termination of parental rights, a permanent placement, including appointing a relative as permanent managing conservator or returning the child to a parent, is appropriate for the child;

(10) [~~(7)~~] for a child whose permanency goal is another planned, permanent living arrangement, the department has:

(A) documented a compelling reason why adoption, permanent managing conservatorship with a relative or other suitable individual, or returning the child to a parent is not in the child's best interest; and

(B) identified a family or other caring adult who has made a permanent commitment to the child;

(11) [~~(8)~~] the department or authorized agency has made reasonable efforts to finalize the permanency plan that is in effect for the child; and

(12) [~~(9)~~] if the child is committed to the Texas Juvenile Justice Department [~~Youth Commission~~] or released under supervision by the Texas Juvenile Justice Department [~~Youth Commission~~], the child's needs for treatment, rehabilitation, and education are being met.

SECTION 6. Section 264.121, Family Code, is amended by adding Subsection (g) to read as follows:

(g) For a youth taking prescription medication, the department shall ensure that the youth's transition plan includes

provisions to assist the youth in managing the use of the medication and in managing the child's long-term physical and mental health needs after leaving foster care, including provisions that inform the youth about:

(1) the use of the medication;

(2) the resources that are available to assist the youth in managing the use of the medication; and

(3) informed consent and the provision of medical care in accordance with Section 266.010(1).

SECTION 7. Section 266.001, Family Code, is amended by amending Subdivision (1) and adding Subdivisions (1-a), (6), and (7) to read as follows:

(1) "Advanced practice nurse" has the meaning assigned by Section 157.051, Occupations Code.

(1-a) "Commission" means the Health and Human Services Commission.

(6) "Physician assistant" has the meaning assigned by Section 157.051, Occupations Code.

(7) "Psychotropic medication" means a medication that is prescribed for the treatment of symptoms of psychosis or another mental, emotional, or behavioral disorder and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state. The term includes the following categories when used as described by this subdivision:

(A) psychomotor stimulants;

(B) antidepressants;

(C) antipsychotics or neuroleptics;

(D) agents for control of mania or depression;

(E) antianxiety agents; and

(F) sedatives, hypnotics, or other sleep-promoting medications.

SECTION 8. Section 266.004, Family Code, is amended by adding Subsections (h-1) and (h-2) to read as follows:

(h-1) The training required by Subsection (h) must include training related to informed consent for the administration of psychotropic medication and the appropriate use of psychosocial therapies, behavior strategies, and other non-pharmacological interventions that should be considered before or concurrently with the administration of psychotropic medications.

(h-2) Each person required to complete a training program under Subsection (h) must acknowledge in writing that the person:

(1) has received the training described by Subsection (h-1);

(2) understands the principles of informed consent for the administration of psychotropic medication; and

(3) understands that non-pharmacological interventions should be considered and discussed with the prescribing physician, physician assistant, or advanced practice nurse before consenting to the use of a psychotropic medication.

SECTION 9. Chapter 266, Family Code, is amended by adding Section 266.0042 to read as follows:

Sec. 266.0042. CONSENT FOR PSYCHOTROPIC MEDICATION. Consent to the administration of a psychotropic medication is valid

only if:

(1) the consent is given voluntarily and without undue influence; and

(2) the person authorized by law to consent for the foster child receives verbally or in writing information that describes:

(A) the specific condition to be treated;

(B) the beneficial effects on that condition expected from the medication;

(C) the probable health and mental health consequences of not consenting to the medication;

(D) the probable clinically significant side effects and risks associated with the medication; and

(E) the generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reasons for the proposed course of treatment.

SECTION 10. The heading to Section 266.005, Family Code, is amended to read as follows:

Sec. 266.005. PARENTAL NOTIFICATION OF CERTAIN [~~SIGNIFICANT~~] MEDICAL CONDITIONS.

SECTION 11. Section 266.005, Family Code, is amended by adding Subsection (b-1) and amending Subsection (c) to read as follows:

(b-1) The department shall notify the child's parents of the initial prescription of a psychotropic medication to a foster child and of any change in dosage of the psychotropic medication at the

first scheduled meeting between the parents and the child's caseworker after the date the psychotropic medication is prescribed or the dosage is changed.

(c) The department is not required to provide notice under Subsection (b) or (b-1) to a parent who:

(1) has failed to give the department current contact information and cannot be located;

(2) has executed an affidavit of relinquishment of parental rights;

(3) has had the parent's parental rights terminated; or

(4) has had access to medical information otherwise restricted by the court.

SECTION 12. Section 266.007(a), Family Code, is amended to read as follows:

(a) At each hearing under Chapter 263, or more frequently if ordered by the court, the court shall review a summary of the medical care provided to the foster child since the last hearing. The summary must include information regarding:

(1) the nature of any emergency medical care provided to the child and the circumstances necessitating emergency medical care, including any injury or acute illness suffered by the child;

(2) all medical and mental health treatment that the child is receiving and the child's progress with the treatment;

(3) any medication prescribed for the child, [~~and~~] the condition, diagnosis, and symptoms for which the medication was prescribed, and the child's progress with the medication;

(4) for a child receiving a psychotropic medication:

(A) any psychosocial therapies, behavior strategies, or other non-pharmacological interventions that have been provided to the child; and

(B) the dates since the previous hearing of any office visits the child had with the prescribing physician, physician assistant, or advanced practice nurse as required by Section 266.011;

(5) the degree to which the child or foster care provider has complied or failed to comply with any plan of medical treatment for the child;

(6) [~~(5)~~] any adverse reaction to or side effects of any medical treatment provided to the child;

(7) [~~(6)~~] any specific medical condition of the child that has been diagnosed or for which tests are being conducted to make a diagnosis;

(8) [~~(7)~~] any activity that the child should avoid or should engage in that might affect the effectiveness of the treatment, including physical activities, other medications, and diet; and

(9) [~~(8)~~] other information required by department rule or by the court.

SECTION 13. Chapter 266, Family Code, is amended by adding Section 266.011 to read as follows:

Sec. 266.011. MONITORING USE OF PSYCHOTROPIC DRUG. The person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication shall ensure that the

child has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days to allow the physician, physician assistant, or advanced practice nurse to:

(1) appropriately monitor the side effects of the medication; and

(2) determine whether:

(A) the medication is helping the child achieve the treatment goals; and

(B) continued use of the medication is appropriate.

SECTION 14. Section 533.0161(b), Government Code, is amended to read as follows:

(b) The commission shall implement a system under which the commission will use Medicaid prescription drug data to monitor the prescribing of psychotropic drugs for [~~children who are~~]:

(1) children who are in the conservatorship of the Department of Family and Protective Services[~~,~~] and

[~~(2)~~] enrolled in the STAR Health Medicaid managed care program or eligible for both Medicaid and Medicare; and

(2) children who are under the supervision of the Department of Family and Protective Services through an agreement under the Interstate Compact on the Placement of Children under Subchapter B, Chapter 162, Family Code.

SECTION 15. The heading to Subchapter A, Chapter 266, Family Code, is repealed.

SECTION 16. The changes in law made by this Act apply to a

suit affecting the parent-child relationship pending in a trial court on or filed on or after the effective date of this Act.

SECTION 17. This Act takes effect September 1, 2013.

President of the Senate

Speaker of the House

I certify that H.B. No. 915 was passed by the House on April 19, 2013, by the following vote: Yeas 138, Nays 0, 1 present, not voting; and that the House concurred in Senate amendments to H.B. No. 915 on May 16, 2013, by the following vote: Yeas 140, Nays 0, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 915 was passed by the Senate, with amendments, on May 15, 2013, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor

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Children's Commission

SUPREME COURT OF TEXAS PERMANENT JUDICIAL COMMISSION FOR CHILDREN, YOUTH AND FAMILIES

HB 915 Implementation Workgroup

Tuesday, June 11, 2013

9:30 am – 12:30 pm

Meeting Notes

For each Section of HB 915, we must consider changes to:

- Policies
- Practices
- Training

Also, we must keep in mind:

- What is in the best interest of the children?
- What is your role?
- What is best for the system?

When does HB915 kick in?

The purpose of the medication determines whether or not a medication is a psychotropic medication – not the type of doctor prescribing or the type of meds. For example, Benadryl can be a psychotropic med or an allergy med.

TRAINING

Training will be integral to this implementation plan.

- How do we get it?
- Large numbers to be trained:
  27,000 kids
  378 contracts with foster homes
  Lawyers, CASAs
- To reach such large audiences we will need: webinars, interactive, online training (Using video is important because modeling helps learning).
  Consider a professional training group to advise on the best way to train each of the groups; will need to develop a core curriculum and follow up with professional

development that is specific to the profession. There might be too many people to reach everyone individually – we must target the professionals who work with the caregivers
- We should reach out to the Foster Alumni Association, Regional Youth Specialists
- Concern – one size fits all will not work, will need accommodations
- Trauma-Informed Care (TIC) Workgroup for DFPS has made a 5 year plan to convert DFPS to a trauma informed system of care.
- Cenpatico has been leading TIC trainings throughout the system.

CONSENT

Further clarification is needed regarding medical consenter policy and practice.

- Who is the Medical Consenter? RTC staff, Caseworker, or the ISY worker?
- RTC gets its info from staff, ISY worker contacts Caseworker prior to consenting to meds, if non-emergency
- How do we resolve a disagreement between Caseworker and ISY worker? DFPS Form2085-B "Designation of Medical Consenter" designates a Primary Medical Consenter and a Backup Medical Consenter in the event the primary Medical Consenter is unavailable. Per CPS Policy, when a child is placed in a staffed residential facility in another region, the I See you worker is designated as the child's Primary Medical Consenter. There was discussion regarding which kind of worker has more accountability and continuity.
- What kind of consultation do we need between the caseworker, the ISY worker and Care staff?
- Youth are mobile which affects continuity
- Should the assessment be different in RTC group?
- In foster homes, there was discussion that consent needs to be real and concerns relayed by CASA about directions to foster parents to fill prescriptions.
-
    - Medical Consenter must feel empowered.
    - Train the physicians.
    - Ex Parte Letter to the Judge - Tex. Fam. Code §266 allows an ex parte letter to the judge
    - Also could request a PMUR.

Setting	**Person Typically Giving Consent**
RTC	ISY Worker (if out of region); Caseworker (in region)
Foster care	Foster Parent
Relative care	Kin

*In any setting, the court may approve youth 16 years old and older, biological parents, or relatives to serve as the Medical Consenter.

Who are the Medical Consenters?

Caseworkers -- for 9% of all kids in foster care

Other -- for 91% of all kids in foster care

(However, much of the foster care population on psych meds is concentrated in the RTCs, so Caseworkers serve around half the kids on psych meds.)

Outcome Measures

- What is our goal?
- What is our outcome measure?
- Fewer kids on psych meds? No, because child well-being is really the goal, so improved accuracy for each child is our desired outcome. We want kids to progress, grow and heal, but developing the most effective agreed-upon process is the best we can do.

How do we improve the consent process?

- We need our Medical Consenters to have tons of information.
- It's best if the Medical Consenter is accessible
- Caregivers need to have a third party making recommendation. (In the case of psych hospitals, for example, they don't want the caregiver to be the same person as the Medical Consenter due to possible conflicts of interest.)

FORMS

New Forms will require more training, specifically for:

- Relatives
- Adoptive Parents – When adoptive agreement signed, the child and the doctor are no longer in STAR Health
- Bio Parents – need training on their rights and ALSO on the actual medications, side effects, etc.
- Youth HHSC developed an age-appropriate training with animated characters

What kind of documentation of consent do we need?

- There is value in standardization
- Most doctors are comfortable with a form, probably already using a form for the file, but it needs to not be too burdensome
- All Agree that the Consent should be documented
- Need a simple form
- HHSC form used for state hospitals is more of a checklist for the Medical Consenter
- Judge Bonicoro's form documents the thought process of the Medical Consenter
- Dr. Rogers pointed out that some states have a prospective system, for example, Illinois has a contract with the med school to review prescriptions. Only about ½% are rejected. Our system is retrospective. Adding forms would be duplicative and might discourage psychiatrists to participate in the network.

What is the Purpose of a Form?

1) Documenting discussion (doctors may have their own forms for this)
2) Encouraging Informed Consent
3) Monitoring symptoms
4) Informing the Judge

- Additional forms might overburden psychiatrists
- Doctor is signing that they said what they said, and this may not be effective
- Who would bear the burden? The Medical Consenter, the medical provider?
- Do not want to break the system, must take a holistic view
- Judge Bonicoro believes her form could be pared down, but would like to see the Preamble to the Parameters be included in the form.
- Perhaps an HHSC Form can be developed by Sept 1st and a more robust form later?

ROLE OF THE GAL/AAL

- GALs and AALs already have access to the Health Passport, but the Passport is not user-friendly. The statute also allows for access to all medical records, but sometimes there are costs associated with requesting medical records, such as doctors charging for pulling the file and making copies.
- CASAs (and foster parents) may have a hard time getting into court to raise concerns about medications. If it is regarding medical care, a statute allows them to petition the court for an order related to medical care, and health care professionals who have concerns regarding a child's medical care can file a letter with the court stating their concerns. (Consider for judicial training – CASA and foster parent access to court if no other parties are filing motions.)
- Need to tell kids that AAL is bound by confidentiality, CASA is not.
- On the medical summaries for the Court, there is a possible training issue for caseworkers or maybe revisions to the statewide court report: judges find it helpful for the current events since last hearing to be at the top of the report. It is important to have historical info but it needs to be easy to read.
- If there is an issue of noncompliance by caregivers, this information needs to make it into the report, and on the Health Passport, and to the doctor.

ASSESSMENT

- Is the Psychological Evaluation a pipeline to medication?
  For any child in Therapeutic Care (the step up from Basic Care), a child receives a psychological evaluation with a clinical psychologist who uses the DSM, and often refers to a psychiatrist.
- Trauma/psycho/social development specialists are often masters level licensed counselors who may be more familiar with non-pharmacological alternatives, but unable to write prescriptions.
- What about a Triage step?
- Who will serve as the gate and what training to we need to implement?
- Is the Medical Home model sufficient to be the gate?
- Dr. Partap has a foster care clinic in Dallas. In this setting the Medical Home model works well. However, a foster care clinic is extraordinary and may not be successful for in the majority of the state.

After the meeting, Judge McCown had some additional thoughts to help clarify:

- Who does the assessment?
- How they do it?
- Can the psychosocial assessment be incorporated into the current assessment system? (If the psychologist/psychiatrist are doing a psychosocial of assessment with robust training about non-pharmacological interventions but still able to diagnosis and prescribe when appropriate.)
- Could we have a highly trained gatekeeper who could sort out which case needs to start with a social worker and which case needs to start with a psychologist?

(DFPS is currently changing the minimum standards regarding the use of Psych Evaluations and Psychosocial Assessments and will share more about this work at the next meeting).

TRANSITIONAL SERVICES

- Use Regional Specialists
- Assign Back up Medical Consenter sooner
- Issue with pediatricians only seeing youth until they are 18. We need doctors who will see them as young adults, too.
- Information Retaining – youth need assistance with their important documents
- Youth have the option between STAR Health and traditional Medicaid when they turn 18
- Need to look at how to make PAL/ New Training More Effective

1) What are the issues with STAR Health young adult providers?

2) Do we switch the youth from STAR Health to traditional Medicaid behind the scenes when they are transitioning? STAR Health has case management – might be able to help set this up. Or do we train doctors better?

ADDITIONAL POPULATIONS

HHSC must coordinate with DFPS to create monitoring system for:

1) Children Dually-Eligible for Medicaid and Medicare (population of about 10 kids)

3) Children in Texas under the ICPC where DFPS has supervisory duties– applies to relatives, NOT RTCs

- Possible solution might be to contract with STAR Health to review this
- Bring ICPC STATE office people to our next meeting
- There might be HIPAA issues and jurisdictional issues
- Consider what can we require as a condition of supervising for other states?
  e.g., a Release of Medical Records. How can we get their medical records?

House Bill 915 reference/item summary	Specific Tasks
SECTION 1 – New Guardian Ad Litem Duties Adds to the duties of a guardian ad litem for a child the responsibility to: • review the medical care provided to the child; and • in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided. *(Amends Texas Family Code §107.002)*	Inform staff through a Protective Services Information Memo
SECTION 2 – New Attorney Ad Litem Duties Adds to the duties of an attorney ad litem for a child the responsibility to: • review the medical care provided to the child; • elicit the child's opinion on the medical care provided; and • for a youth at least 16 years of age, advise the youth of their right to ask the court to authorize the youth to be his or her own medical consenter under Section 266.010 of the Family Code. Note: §266.010 is the provision that governs when a youth at least 16 years of age can be authorized by the court to consent to the youth's own medical care. *(Amends Texas Family Code §107.003)*	Inform staff through a Protective Services Information Memo
SECTION 3 – Adds definitions of Advanced Practice Nurse and Physician Assistant Adds definitions for Advanced Practice Nurse and Physician Assistant by referring to the relevant sections of the Texas Occupations Code. *(Amends Texas Family Code §263.001)*	Add this language to staff communications and publications where needed
SECTION 4 – Permanency Hearings Adds the following new responsibilities to the list of things the court is required to do at each Chapter 263 permanency hearing: • review the medical care provided to the child; • ensure the child has been provided the opportunity to express the child's opinion on the medical care provided; • for a child receiving psychotropic medication, determine whether the child: ** has been provided appropriate **psychosocial therapies, behavior strategies, and other non-pharmacological interventions**; and ** has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days. *(Amends Texas Family Code § 263.306(a))*	Revise: • Court report prompts, • CPS policy • Training for staff and caregivers/medical consenters Possible CPS Residential Child Care (RCC) contract revisions

SECTION 5 – Placement Review Hearings Adds to the list of things the court is required to do at each Chapter 263 placement review hearing the new responsibilities to determine whether: • the child is receiving appropriate medical care; • the child has been provided the opportunity to express the child's opinion on the medical care provided; and • for a child receiving psychotropic medication, determine whether the child: ** has been provided **appropriate psychosocial therapies, behavior strategies, and other non-pharmacological interventions**; and ** has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days. *(Amends Texas Family Code § 263.503(a))*	Revise: • Court report prompts, • CPS policy • Training for staff and caregivers/medical consenters Possible CPS/RCC contract revisions
SECTION 6 – Transition Plan Adds a new requirement regarding the Transitional Living Services Program. DFPS must ensure that a youth's transition plan includes provisions to assist the youth in managing medication usage after exiting foster care, including information that educates the youth about: • the use of the medication; • resources available to assist the youth in managing the medication; and • informed consent and the provision of medical care under §266.010(l). Note: §266.010(l) is the provision that requires DFPS or the Child Placing Agency to advise a youth 16 years of age or older of the youth's right to request that the court authorize the youth to be his or her own medical consenter. *(Texas Family Code § 264.121)*	Incorporate requirements into Transition Planning policy and practices currently being revised Update Youth Website Include in plan: court may allow 16 + youths to consent to some or all of their medical care. RCC contract revisions if needed Coordinate with HHSC and STAR Health to inform them of these transition planning requirement changes which impact: • Service Coordination and Service Management provided by STAR Health for young people over the age of 18 • STAR Health communications and publications to this age group

SECTION 7 - Adds definitions of Advanced Practice Nurse, Physician Assistant, and Psychotropic Medication Adds definitions to the section of the Family Code that deals with medical care and education. • Defines "advanced practice nurse" and "physician assistant" by reference to the relevant sections of the Occupations Code (identical to SECTION 3). • Defines "psychotropic medication" to mean a medication that is prescribed for the treatment of symptoms of psychosis or another mental, emotional, or behavioral disorder and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state. The term includes the following categories *psychomotor stimulants; *antidepressants; *antipsychotics or neuroleptics; *agents for control of mania or depression; *antianxiety agents; and *sedatives, hypnotics, or other sleep-promoting medications. Note: This definition was based on Texas Health and Safety Code, Section 574.101(3), definition of "psychoactive medication." *(Amends Texas Family Code §266.001)*	Add this language to staff communications and publications where needed
SECTION 8 - Medical Consenter Training Adds new components to the training that medical consenters are currently required to have. Medical consenter training must include training related to informed consent for psychotropic medications, and the **psychosocial therapies, behavior strategies, and other non-pharmacological interventions** that should be considered before or concurrently with the administration of psychotropic medications. Each medical consenter must acknowledge in writing that they: • have received the training, as described above; • understand the principles of informed consent for psychotropic medication; and • understand that non-pharmacological interventions should be considered and discussed with the prescribing practitioner before consenting to the use of a psychotropic medication. *(Amends Texas Family Code §266.004)*	Revise training, policy, internal and external communications Develop Medical Consent Mailbox- include notice in trainings - respond to medical consenter's questions. Revise Medical Consent training to meet requirements, including the acknowledgment process and information related to young people who are their own medical consenters. Develop specialized training for Human Services Technician (HST) Plan and coordinate provision of training Coordinate with RCC on changes to Residential Contracts

SECTION 9 – Requirement for Informed Consent Before Prescribing Psychotropic Medications Outlines requirements regarding informed consent for psychotropic medications. Consent to the administration of a psychotropic medication is valid only if: • the consent is given voluntarily and without undue influence; and • the person authorized by law to consent for the foster child receives verbally or in writing information that describes: ** the specific condition to be treated; ** the beneficial effects on that condition expected from the medication; ** the probable health and mental health consequences of not consenting to the medication; ** the probable clinically significant side effects and risks associated with the medication; and ** the generally accepted **alternative medications and non-pharmacological interventions** to the medication, if any, and the reasons for the proposed course of treatment. *(Adds new Texas Family Code §266.0042)*	Revise CPS policy to add Human Services Technician (HST) staff to those staff designated as Medical Consenters Finalize Informed Consent Brochure and post on DFPS website Coordinate with RCC on changes to Residential Contracts Coordinate with HHSC and STAR Health on the role of Prescribing Providers in the informed consent process, including adoption of a form if a form is needed.
SECTIONS 10 and 11 – Notify Parents of Psychotropic Medication DFPS is required to notify a child's parents of: • the initial prescription of a psychotropic medication to a child in foster care; and • any change in dosage of the psychotropic medication at the first scheduled meeting between the parents and the child's caseworker after the date the psychotropic medication is prescribed or the dosage is changed. DFPS is not required to provide the notice to a parent who can't be located, who has executed an affidavit of relinquishment, who had rights terminated, or who has had access to medical information otherwise restricted by the court. *(Amends §266.005 Texas Family Code)*	Revise CPS policy Revise Medical Consent training and other training for staff and Caregivers Coordinate with Residential Contracts

SECTION 12 – Judicial Review of Medical Care Requires that for a child receiving psychotropic medication, the summary of medical care that is presented to the court at each hearing where medical care is reviewed must include (in addition to the other information currently required by law to be included for all children): * a description of the **psychosocial therapies, behavior strategies, or other non-pharmacological interventions** that have been provided to the child; and * the dates since the previous hearing of any office visits the child had with the prescribing physician, physician assistant, or advanced practice nurse as required by SECTION 13 of the bill. *(Amends Texas Family Code §266.007(a))*	Revise: • Court report prompts • CPS policy • Training for staff and caregivers/medical consenters (Implementation tasks in Sections 8 and 9 support this section) Possible Residential Contracts revisions
SECTION 13 - Monitoring Use of Psychotropic Medications at Least Every 90 Days Requires the medical consenter for a child in foster care to ensure that a child prescribed a psychotropic drug has an **office visit** with the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days to allow the practitioner to: * appropriately monitor the side effects of the drug; and * determine whether the drug is helping the child achieve the treatment goals and whether continued use of the drug is appropriate. *(Adds new Texas Family Code §266.011)*	Revise CPS policy and training (Implementation tasks in Sections 8 and 9 support this section) Possible Residential Contracts revisions
SECTION 14 – Monitoring New Populations of Children Requires the HHSC to use Medicaid prescription drug data to monitor the prescribing of psychotropic drugs for: * children who are in DFPS conservatorship and enrolled in STAR Health or who are eligible for both Medicaid and Medicare ("dually-eligible" children); and * children who are under the supervision of DFPS [but not in DFPS conservatorship] through an agreement under the Interstate Compact on the Placement of Children (ICPC). *(Amends Texas Government Code §533.0161(b))*	IT changes to allow HHSC to identify children in ICPC placements for medication monitoring Develop processes for monitoring children who are dually eligible for Medicaid and Medicare HHSC and DFPS will coordinate to determine medication monitoring processes
SECTION 15 - Technical Correction	
SECTION 16 – Scope of Bill Changes in law apply to a suit affecting the parent-child relationship pending in a trial court ON, OR FILED ON OR AFTER, the effective date of September 1, 2013.	

Consenting to **Psychotropic Medications**

Texas Department of Family & Protective Services

Consenting to Psychotropic Medications

This guide will help medical consenters talk to doctors and make decisions about psychotropic medication.

Most children in the custody of Child Protective Services don't need psychotropic medications. But all abused or neglected children who are removed from their homes suffer emotional stress, and some act out in unhealthy ways. Most children slowly heal and learn to control their behavior with patience, understanding, and clear and consistent rules,

Of course, each child is unique. Some children need medication to help them get better. Some may need it only briefly to relieve stress and deal with trauma. Others may need psychotropic medications long-term to treat mental health disorders.

Psychotropic medications help some children feel better and function at home, in school, and in their daily lives. However, psychotropic medications must always be part of a plan that includes other help such as therapy, consistent house rules, and teaching positive behavior.

Try other things before agreeing to psychotropic medications

- Talk to the child's CPS caseworker and child placing agency's case manager or treatment team about how to manage difficult behavior and help the child deal with emotional stress.
- Ask the CPS caseworker or agency about classes that can help you deal with a child's behavior (behavior intervention or trauma-informed care).

Find therapy for the child and talk to the therapist about your concerns and how to get help.

- Work with the child's therapist, school, child-placing agency, caseworker, and others to find interventions that work. Make sure you all use the same interventions.

If the child is still having serious symptoms or isn't getting better, then you should talk to a doctor.

Things you should do before and during the doctor's appointment

Talk to children about why they are seeing a doctor and about medications

Talking helps children feel more in control, builds trust, and can make treatment more successful. Use words children understand. Children should have more input into decisions about psychotropic medications as they get older but, as medical consenter, you must decide based on what is best for the child. The CPS caseworker will keep the child's birth parents informed about medications their child is taking.

Be ready to tell the doctor about the child's emotions, behavior, and symptoms and let the child share concerns with the doctor.

- What is the child's story? Can the child tell you what is wrong?
- Did something new happen to upset the child?
- How is the child doing in school, with friends, when visiting with family?
- What behaviors concern you and where do they happen?
- How often do these behaviors happen and how long do they last?
- Are these behaviors mild, moderate, severe?

- What have you tried to deal with these behaviors? What worked or didn't work?
- How consistent are these interventions?
- Is the child getting therapy and is it helping?
- Is the child taking any medications? Have they helped? Were they taken as prescribed? Side effects?

Bring important information to the appointment, like:

- Evaluations (psychological, educational, developmental, etc.).
- A list of any medications the child takes or has taken in the past (see the child's Health Passport).
- The child's abuse and neglect history and placement history.
- The medical and mental health history of the child and birth family if available.
- How to contact the child's primary care physician, CPS, therapist or other providers.

Knowing what to expect can help you get ready for the appointment

Always be at appointments about psychotropic medications

The law requires medical consenters to take part in the child's health care appointments. But, it is especially important for you to participate when psychotropic medications are discussed, prescribed or monitored. The doctor needs to know the child's history and how the child is doing to recommend treatment. You need to talk to the doctor and ask questions to make the best decision before consenting to a psychotropic medication or other treatment.

Doctor's won't prescribe psychotropic medication in every case

There are many reasons why a doctor may not prescribe a psychotropic medication. A doctor may need more information or want to try other things first—perhaps a special type of therapy.

If the doctor recommends medication, let the child talk about any concerns. Here are some things you can ask the doctor:

- Are there other things we should try first?
- Why do you think this is the best treatment?
- Has it helped others with similar conditions?
- What's the medication called and does it have other names?
- What symptoms does it treat?
  How long before it works?
  What are the side effects?
- Is this medication addictive?
  Can it be abused?
- What is the dose and how often should the child take it?
- Does the child need laboratory tests before or while taking the medication?
- Does the child need to avoid any foods, medications, or activities?

- How long will the child need to take this medication and how do we decide when to stop?
- What do I do if the child becomes ill, misses doses, or has side effects?
- Do I need to tell my child's school or day care about this medication?

If the child is prescribed a psychotropic medication and is already taking another one, you should ask:

- Does the child finish the old medication before starting the new one?

- Does the child keep taking both the old and new medications? For how long?

(Always read and keep the medication information the pharmacy gives you when you fill a prescription.)

A child taking a psychotropic medication must have a check-up every 90 days

You must take any child on a psychotropic medication to the prescribing doctor at least every 90 days. You must talk to the doctor about how the child is doing. You must take the child for any regular lab work the doctor has requested before the follow up visits.

Take with you to the appointment:

- Any new medical, psychological, developmental or educational evaluations.
- Any new medical history.
- A list of all the child's current medications and dosages.

Be sure to give the child a chance to share concerns and ask questions. Talk to the doctor about:

- How the medication is working.
- Any changes in behavior, mood, appetite, sleep, or school performance.
- Anything new in the child's life that could upset them.
- Changes in how the child gets along with others.
- Any suspicions about alcohol or drug abuse or any other concerns.
- Any side effect the child is having, including weight gain or loss.
- Therapy and other interventions you are trying.
- How much longer the child will need the medication.

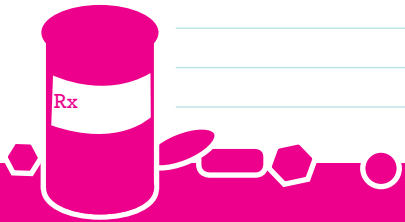
When you have problems or concerns between visits

Talk to the prescribing doctor if:

- You have any concerns about side effects.
- The child is not getting better or is getting worse.
- The child is a danger to himself or others.

After you speak with your doctor, if you still have these concerns call STAR Health Member Services at 1-866-912-6283. Please be aware that STAR Health continually monitors all psychotropic medication prescribing and will conduct a formal review if the prescribing is not within recommended guidelines. A formal review includes examining medical records, a discussion between a STAR Health child psychiatrist and the prescribing doctor and a written report from the STAR Health psychiatrist.

Notes



Notes

Texas Department of Family & Protective Services

Stock Code no. P20312-0000

Below are the types of DFPS types of Medicaid and Medicaid types associated with DFPS showing whether they are in STAR Health or Traditional Medicaid.

STAR Health

- Foster Care Medicaid: children in **paid foster care** and **kinship care**
- Medicaid for Transitioning Foster Care Youth **(MTFCY)**.
  - Young people may opt out of STAR Health to Traditional Medicaid – but lose specialized service coordination/management available in STAR Health.
  - They do not lose Medicaid coverage by opting out but may lose their Medicaid temporarily if they fail to respond to mail sent to their address or if their income makes them ineligible.
  - They may also opt back in.
  - PAL, Transition Centers and CPS Wellbeing Specialists are resources to assist young people who may need to re-apply for Medicaid or re-select STAR Health.

Traditional Medicaid - Fee for Service; must choose a Dental Managed Care Organization (DMO):

- Foster Care Medicaid: Children placed in authorized placements through **ICPC**.
- **Adoption Assistance** Medicaid: Upon signing the Adoption Agreement.
- **Permanency Care Assistance**: Verified kinship families who have been licensed for 6 months and receive Permanent Managing Conservatorship.

Children's Commission
SUPREME COURT OF TEXAS PERMANENT JUDICIAL COMMISSION FOR CHILDREN, YOUTH AND FAMILIES

Justice Eva Guzman, Chair

Tina Amberboy, Executive Director

Travel Reimbursement Guidelines

This program is federally funded and is thereby governed by the reimbursement policies of the Children's Commission and the Supreme Court of Texas. All travel expenses will be paid in accordance with the following policies. *Reimbursements for personal expenses, alcoholic beverages and gratuities are not allowed.*

Reimbursement Forms
Please complete the Children's Commission travel reimbursement form in full. Please print, sign and date your form. Make a copy for your records and mail the original form, with receipts attached to **The Supreme Court of Texas Children's Commission P.O. Box 12248 Austin, TX 78701**. If you have any questions or need assistance completing the form, please contact us at (512) 463-4926 or Rashonda.thomas@txcourts.gov.

***Match Form** (if applicable)*
The Children's Commission match form MUST also be completed to prevent delay in receiving your reimbursement.

Receipts
Receipts are required for lodging and transportation expenses. Meal receipts are not required.

Transportation
The Children's Commission will reimburse economy airfare or 56.5 cents per mile for travel by personal automobile.

Mileage Calculation
Supporting documentation for mileage must include a printout from MapQuest (www.mapquest.com). In determining mileage you should use your headquarters address as city of origin.

Meals
The maximum should not be claimed unless the actual expenditures equal or exceed the maximum allowable rate. The Children's Commission will reimburse for meals up to a maximum of $71 per day for overnight travel. The first and last day of travel will be limited to actual expenses up to $53.25 per day. Meal expenses incurred on non-overnight travel will not be reimbursed.

Lodging
The single occupancy rate of $108 plus applicable taxes for your hotel room will be reimbursed for arrival on the first day of a conference or meeting through the last day of conference or meeting. Additional room nights, guests and incidental are not reimbursable.

All reimbursement claims must be submitted within 45 days of travel.

Children's Commission
SUPREME COURT OF TEXAS PERMANENT JUDICIAL COMMISSION FOR CHILDREN, YOUTH AND FAMILIES

CHILDREN'S COMMISSION
PO. Box 12248 ~ Austin, TX 78701
512463-4924 ~ 512-463-8895 (fax)

TRAVEL REIMBURSEMENT REQUEST

PLEASE MAIL ORIGINALS TO THE CHILDREN'S COMMISSION. DO NOT FAX.

Please Allow 30 days for processing.

IDENTIFICATION. **Please complete in full.**	
Name:	Social Security Number:
Title:	Email:
Business Address:	Phone:
City/State/Zip:	Fax:

CONFERENCE/MEETING DETAILS. **Please complete in full.**
Committee Name:
Conference Name:
Location:
Dates:

TRANSPORTATION: **Receipts and supporting documentation must be attached. MapQuest is used to calculate mileage between your headquarters and conference/meeting city.**

Airfare			$
Mileage *(personal vehicle)*	_____	x 0.565 cents/mile	$
Rental Car			$
Taxi			$
Shuttle			$
Parking			$
Tolls *(receipts not required)*			$
		TOTAL TRANSPORTATION	$

MEALS: **See reimbursement Guidelines for the maximum meal allowance per day.**

Date							
Meals							

TOTAL MEALS $

LODGNG: **Maximum: $108 per night plus taxes. Lodging receipt required.**

Date							
Lodging							

TOTAL LODGING $

INCIDENTAL EXPENSES: **Receipts and supporting documentation required.**

Internet access		$
Baggage		$
Gasoline *(rental vehicles only)*		$
Other expenses		$
	TOTAL INCIDENTAL	$
	TOTAL REIMBURSEMENT	$

I CERTIFY THAT:

1. The amounts listed are actual expenses paid personally by me for the purpose stated.
2. I have not been nor will be reimbursed from any other source for any of the expenses listed.
3. This request is correct to the best of my knowledge.

Signature: Date:

NON-FEDERAL MATCH

Contributor Name: _____ Date: July 23, 2013

Title: HB 915 Implementation Workgroup Meeting

Location: Austin, Texas

Brief Description of Contribution

Attendance at the HB 915 Implementation Workgroup Meeting,
State Bar of Texas, Texas Law center, 1414 Colorado Street, Austin, TX 78701

Hours Spent in Meeting		
Travel time		
Total Hours Contributed	**0**	
Hourly rate		*If you are uncertain of your hourly rate, you may divide your annual salary by 2080 to get it.*
Total Contribution	**$**	

I certify that the amounts listed:

1. Are not included as contributions for any other federally-assisted project or program.

2. Are not paid by the Federal Government under another award, except where authorized by Federal statute to be used for cost sharing or matching.

Contributor's Signature	**Date**

Please sign and return to Tina Amberboy at tina.amberboy@txcourts.gov