Children's Commission

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

HB915 Implementation Workgroup

Tuesday, August 27, 2013

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

TABLE OF CONTENTS

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HB 915 Implementation Workgroup

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

Tuesday, August 27, 2013
9:30 am – 12:30 pm

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

9:45 a.m. **Facilitated Discussion Regarding Implementation**

DFPS Update on HB915 Implementation – Liz Kromrei

- ICPC/Dually-Eligible (Section 14)
- Consent Form (Section 9)
  - Standardized Court Report cross-walked and augmented
- Human Services Technician (Section 13)
- Psychosocial Therapies, Behavior Strategies, and Other Non-Pharmacological Interventions (Section 4)
  - DFPS/HHSC Assessments Review
- Training (all Sections)

Reports from Stakeholders re Implementation Plans

12:10 p.m. **Ongoing Work --Did we accomplish what we set out to do?**

Review Charge of Workgroup:

DFPS will create an implementation plan for HB915, by soliciting input and collaboration from the Children's Commission and interested stakeholders. This Workgroup will:

- Identify existing practices and policies that support HB915;
- Make recommendations regarding new policies required to support the implementation and ongoing execution of the DFPS's duties under the new bill;

- Identify training needs required to support new practices, expanded collaboration, and communication to support the objectives and the mandates of HB915; and
- Meet regularly to ensure ongoing stakeholder involvement and communication about implementation progress

12:25 Next Meeting

- Provide periodic updates to DFPS Commissioner and Implementation Workgroup
- Reconvene in January or February 2014

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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Supreme Court of Texas
Permanent Judicial Commission for Children, Youth and Families
HB915 Implementation Workgroup

July 23, 2013
Hatton Sumners Room
Texas Law Office
1414 Colorado Street
Austin, Texas

Toll free: 1-877-820-7831
Participant Passcode: 629943#

MEETING MINUTES

ATTENDANCE OF MEMBERS

Name			Name	
Judge F. Scott McCown	In Person		Judge John Hathaway	In Person
Judge John Specia	In Person		Shaniqua Johnson	In Person
Pam Baker	In Person		Katherine Keenan	In Person
Katherine Barillas	In Person		Liz Kromrei	In Person
Tymothy Belseth	In Person		Richard Lavallo	In Person
Gail Biro	In Person		Stephanie LeBleu	In Person
Laura Blanke	In Person		Diana Martinez	In Person
Judge Karin Bonicoro	In Person		Pamela McPeters	In Person
Allison Brock	In Person		Tyrone Obaseki	In Person
Dan Capouch	In Person		Cynthia O'Keeffe	In Person
David Cross	In Person		Katie Olse	In Person
Molly Czepiel	In Person		Anu Partap	Teleconference
Audrey Deckinga	In Person		Judy Powell	In Person
Jennifer Deegan	In Person		Karyn Purvis	In Person
Mary Dingrando	In Person		James Rogers	In Person
Tracy Eilers	In Person		Carol Self	In Person
Michelle Erwin *(attending on behalf of Kate Volti)*	In Person		Andrea Sparks	In Person
Cheryl Fisher	In Person		Lee Spiller	In Person
Heather Fleming	In Person		Ann Strauser	In Person
Mike Foster	In Person		Toni Watt	In Person
Stacy Gilliam	In Person		Eric Woomer	In Person
Jennifer Goodman	In Person		Tina Amberboy	In Person
David Harmon	In Person		Kristi Taylor	In Person
Ashley Harris	In Person		Mary Mitchell	In Person

I. CALL TO ORDER

Judge McCown called the meeting to order at 09:30 a.m., and invited attendees to introduce themselves.

II. ASSESSMENT

Judge McCown invited DFPS to provide an overview of common practices. Ms. Keenan briefed that once a child is removed the child will have a Texas Health Steps(well check) which includes a behavioral and developmental screening. This well check should be accomplished within 30 days by a pediatrician contracted with STAR. Ms. Deckinga confirmed that, per residential provider contracts, licensed placements must take a child to the doctor within 30 days.

Dr. Harmon estimated that current statistics show 45% get screened within 30 days and 70 % are screened within 90 days. Ms. Deckinga clarified that with Relative Caregivers it is more difficult to meet the goals.

DFPS will provide breakdown of children in the 45% and 70% (relative v. foster parent)

Judge McCown asked whether the problem is caused because appointments aren't being made or is it that that someone isn't logging it into the system.
Possible reasons for the problems are:

- The system is not organized
- There are not enough STAR Health Pediatricians
- Accountability, this is not a priority and we are not holding people accountable
- Provider breakdown
- Relatives are overwhelmed trying to get the child into school, etc.

Texas Health Steps (THSteps), formerly known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, is specifically a children's program under Texas Medicaid which provides medical and dental preventive care and treatment to Medicaid clients who are birth through 20 years of age. THSteps assists eligible recipients and their parents or guardians to:

- Find a qualified medical or dental provider enrolled in Medicaid
- Set up appointments to see a doctor or dentist through THSteps Outreach
- Arrange transportation or reimbursement for gas money to see a doctor or dentist
- Answer questions about eligible services.

The following are some of the services provided by the THSteps program:

- Preventive Care Medical Checkups and Services
- Dental Checkups and Treatment Services
- Comprehensive Care Program (CCP)
- Laboratory Services

Dr. Harmon clarified that EPSDT is a federal law that requires certain components of a well child visit to be covered by Medicaid; it covers gathering history, physical exams, review of systems, development survey, Mental Health screen, and lab work. It also provides information about the child's physical health, developmental, mental/behavioral health, and identifies their needs. The Mental Health screening must assess current behavioral health and behaviors, there is no standardized form that pediatrician use, it is not diagnostic, but a screen for externalizing behaviors (violent outburst), or internalizing behaviors (depression).

Medicaid does not have a specific tool for mental health screenings. The American Academy of Pediatrics (AAP) has a recommended mental health screen tool, so there is no need to develop a new tool. The EPSDT screen is online via the STAR Health website; it is a recommended form but is not a validated tool like the AAP. We need a standardized form to assess the behavioral mental health with trauma. Judge Hathaway recommended completing a trauma screen in addition to the mental health screen. Dr. Harmon commented there are trauma screens that are appropriate for pediatricians to use.

In the discussion of current practices, the hypothetical child is referred to a therapist for further assessment. Youth For Tomorrow (YFT) uses psychological evaluations so sometimes kids are getting evaluated twice a year because of the requirement that new placements must have psychological evaluations that are current within six months. (DFPS is looking into changing that requirement in licensing to allow YFT to use psychosocial evaluations accomplished by a masters-level professional which might include a Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), or a Licensed Marriage and Family Therapist (LMFT). Certain tools determine who should administer the test to ensure fidelity to the test.

The DFPS Trauma Informed Care Workgroup has a subcommittee that has extensively researched the various trauma screening and assessment tools. However, trauma screens and assessments are just one part of a complete mental health assessment.

Child and Family Functional Assessment (CAFA) used by Providence, not an assessment as much as an organized way of collecting history and data.

Who makes the decision to refer for assessment? Pediatrician? Shouldn't the assessment involve talking to the family, teachers, and friends? Pediatricians get info primarily from Medicaid/CHiP (two years of claims on Health Passport which STAR get through the daily notification system)

STAR does not require clinicians to gather family, school, other history.

Service level determination process gathers/compiles information from various sources but when it's an emergency removal, they don't have a lot of into to pass on yet.

Judge Hathaway asked about a mid-level psychosocial, seems like they would be cheaper and faster.

In a Collaborative Care model, the behavioral providers are the primary care providers and care managers (they coordinate the physical and behavioral health rather than the physical health provider, usually the pediatrician, managing the physical health and then referring out to a psychologist for a psychological evaluation in a separate appointment or system).

Drs. Toni Watt and Anu Partab have pilot projects that are using collaborative models).

III. CONSENT

Two ideas about the purpose of Informed Consent Forms:

1) Achieving Informed Consent

2) Documenting Informed Consent

Eric Woomer commented that many psychiatrists already have forms they use to document consent. He can provide samples of practice forms being used.

If STAR were to try to work with the psychiatrists' forms there would be two approaches:

- STAR could review all ped/psych consent forms already being used and approve.
- STAR could require a particular consent form be used

We could also consider taking the provider's name off the Consent Form.

IV. TRAINING

DFPS has a new online training for Medical Consenters, not yet in Spanish, but does include Individual Education Plans, and placeholders for HB915

Lee Spiller suggested referring to consenters to the FDA approved medical guides; suggested put all the links into the training and not links within links

How is the Medical Consenter training documented? How often is training updated? Is the consenter required to taka refresher course?

Kinship has a more brief, more abbreviated training. How abbreviated? The consenter is required to take a comprehension test at the end of training to receive their certificate.

New Brochure (Tab 6) Consenting to Psychotropic Medications

One suggestion edit is include that the Medical Consenter has the right to refuse consent.

Also, it should be stated that older youth have the right to be the consenter.

For the training that will given to the network of providers, it is not clear yet because we're not sure what everyone will agree to and what should be done in accordance.

We should also consider a post review system for those instances where the consenter declines or does not fill a prescription.

Training – we don't want to stigmatize the medications or the psychiatrists

We want to ensure the Medical Consenter is trained on non pharm interventions

There was discussion regarding the definition of “nonpharmacological interventions.” At this point it is not clear. Medicaid benefit package determines what is covered.

V. ACTION PLAN REVIEW

DFPS update on implementation

Next Meeting will be August 27, 2013

H.B. 915, SECTION 14 (Psychotropic Drug Monitoring)
Implementation Discussion
August 27, 2013

BACKGROUND

H.B. 915, SECTION 14 requires HHSC to use Medicaid prescription drug data to monitor prescribing of psychotropic medications for foster care children who are dual eligible and not in STAR Health, or under supervision of DFPS through an Interstate Compact on the Placement of Children (ICPC) agreement.

Text

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.

AGENDA

1. Interstate Compact Children/Youth: Data*

a) 452 Unique ICPC Children/Youth
   i. 309 enrolled in Medicaid
      - 118 enrolled in FFS
      - 191 enrolled in a managed care program (including dental)
   ii. 143 not enrolled in Medicaid

b) Analysis of the 452 ICPC Children/Youth
   i. *Age*
      - 85% or 386 are younger than 3 years, with 105 of the 386 less than 1 year old
      - 15% or 71 are between 3 and 18 years
      - 8% or 35 are over the age of 18 and still considered in conservatorship of their state

   ii. *Placement*
      - 23% are in an adoptive home placement
      - 6 % are in a foster home placement
      - 2% are in a basic child care residential setting
      - 51% are in a relative or kinship home
      - 17% are placed in the home of a legal guardian or non-custodial parent
      - 2% are placed in an independent living/own home setting

iii. *Psychotropic Drug Use*
- 56 total Medicaid ICPC Children/Youth were prescribed at least 1 psychotropic medication
  - 10 FFS / ICPC Children/Youth were prescribed at least 1 psychotropic medication
  - 46 managed care / ICPC Children/Youth were prescribed at least 1 psychotropic medication
- 12 unique Medicaid ICPC Children/Youth fall outside of the 2010 DFPS psychotropic parameters due to the prescribing of 19 unique providers.

2. Dual Eligible Children: Data*

a) Children Enrolled in Medicare and Medicaid (i.e., Dual Eligible) *and* in the Conservatorship of DFPS
   i. 2 Children
   ii. Both in Fee-For-Service Medicaid

b) Analysis of the 2 Dual Eligible Children
   i. Age
      - 2 years old
      - 3 years old

   ii. Diagnoses
      - End Stage Renal Disease and Kidney Failure
      - Stage 4 Renal Failure

   iii. Placement
      - Both are in specialized foster homes

   iv. *Psychotropic Drug Use*
      - Neither child was prescribed a psychotropic medication that was billed to Medicaid; therefore, neither child fell outside the 2010 DFPS psychotropic parameters.

3. ICPC Children/Youth: Monitoring Implementation Plan

a) Develop regular process for sharing DFPS data with HHSC / contractor.

b) Vendor Drug Program (VDP) Pharmacy Retrospective Drug Utilization Review contractor to analyze pharmacy and medical claims and MCO encounter data quarterly, following most current DFPS parameters.
   i. GOAL: Analyze first quarter data by January 15, 2014 (i.e., 2 weeks after end of quarter).

c) VDP Retrospective Drug Utilization Review contractor to send prescriber educational letters.

i. GOAL: Send letters by January 31, 2014 (i.e., within one month after end of quarter).
ii. Provide outcome report to HHSC on clients for whom letters were sent in previous quarter.

d) Inform MCOs when letters are sent to network prescribers due to the MCO client's medication usage.

e) Possibly have VDP regional pharmacist's follow-up one-on-one with prescribers. This includes working the Office of the Medical Director at HHSC and DFPS to establish protocol for following up with prescribers and handling issues.

4. Dual Eligible Children/Youth: Monitoring Implementation Plan

a) Develop regular process for sharing DFPS data with HHSC / contractor.

b) VDP Retrospective Drug Utilization Review contractor to analyze pharmacy and medical claims / encounter data quarterly, following DFPS parameters.
i. GOAL: Analyze first quarter data by January 15, 2014 (i.e., 2 weeks after end of quarter).

c) VDP Retrospective Drug Utilization Review contractor to send prescriber educational letters.
i. GOAL: Send letters by January 31, 2014 (i.e., within one month after end of quarter).
ii. Provide outcome reports to HHSC on clients for whom letters were sent in previous quarter.

d) Inform MCOs when letters are sent to network prescribers due to the MCO client's medication usage.

e) All dual eligible children enrolled in Medicaid/Medicare and not in a Medicaid managed care program will be in the Texas Medicaid Wellness Program beginning March 1, 2014. This program provides care coordination and related services to all clients in the program and more extensive care coordination for clients deemed "high risk." See 1 TAC §354.1415 for all contractor requirements and conditions for participation in the Texas Medicaid Wellness Program.

**Assumptions*

- *ICPC and Dual Eligible data pulled by DFPS for 05/31/2013.*
- *DFPS 2010 Psychotropic Parameters used for analysis.*
- *HHSC reviewed 6 months of data to determine Medicaid eligibility, psychotropic drug use, and parameters – January 1, 2013 – June 30, 2013. On an ongoing basis the amount of history reviewed will be less.*

PSYCHOTROPIC MEDICATION TREATMENT CONSENT

CPS – MEDICAL SERVICES

Purpose: The person leally authorized to consent to medical care on behalf of a child in DFPS conservatorship uses this form to document informed consent for a new psychiatric medication.
Directions: After completing this form, the medical consenter provides a copy of the form to the DFPS caseworker for the child. The caseworker files it in the child's file.

I am providing consent for _____
Child's name

To receive treatment for _____
Condition being treated

With the following Psychotropic Medication:

_____

- I received information describing

  (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.

- I have been given the opportunity to ask questions.
- This consent is given voluntarily and without undue influence.
- I am the child's Medical Consenter.
- I understand that I have the right to withdraw my consent for this treatment at any time.

_____
Medical Consenter (print name)

_____ Date _____
Medical Consenter (signature)

_____ Date _____
Acknowledged by Prescribing Provider or Designee

Mental Health/Behavior Health Services Covered under STAR Health

Behavioral Health Services:

- Inpatient and outpatient mental health services:
  - Medications
  - Pharmacological Regimen Oversight
  - Psychiatric Diagnostic Evaluations
  - Psychological and Neuropsychological Testing
  - Psychotherapy and counseling services
  - Narcosynthesis
  - Family Therapy or Counseling Services
  - Psychiatric partial and inpatient hospital services for members 21 and under
  - Partial Hospitalization/extended day treatment for members over 21
  - Intensive outpatient treatment/day treatment for members over 21

- Mental health rehabilitative services for children who meet the criteria for having a serious mental illness
- Outpatient chemical dependency services and residential care
- Detoxification services
- Psychiatry services
- Medications and Lab services

STAR Health Service Management also offers the following specialized BH programs:

- Intellectual Developmental Disabilities (IDD) Disease Management
- Diabetes Management specifically tailored for members with comorbid BH issues
- Complex Case Management

Types of Providers Covered:

- Psychologist and Licensed Psychological Associate (LPA) services
  - LPA services must be performed under the direct supervision of a licensed, Medicaid-enrolled psychologist.
- Psychiatrist and Physicians
  - Nurse practitioner (NP) and Physician assistant (PA) services must be performed under the direct supervision of a Physician
- Psychotherapy and counseling services that are provided by LCSWs, LMFTs, and LPCs are benefits of Texas Medicaid for clients of any age who are experiencing a significant behavioral health issue that is causing distress, dysfunction, or maladaptive functioning as a result of a confirmed or suspected psychiatric condition as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).

Mental Health Targeted Case Management and Mental Health Rehabilitative Services:

Medicaid clients receive an initial screening and assessment to determine their eligibility and level of need for Mental Health Targeted Case Management and Mental Health Rehabilitative Services. The priority population consists of Adults who are assessed and determined to have a severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder and children and adolescents ages 3 through 17 years with a diagnosis of mental illness who exhibit serious emotional, behavioral

or mental disorders and who have a serious functional impairment; or are at risk of disruption of preferred living or child care environment due to psychiatric symptoms; or are in enrolled in a school's special education program because of a serious emotional disturbance.

- For those individuals 18 and over
  - Adult Day Program
  - Medication Training and Support
  - Crisis Intervention
  - Skills Training and Development
  - Psychosocial Rehabilitative Services
  - Crisis Intervention
- For children and adolescents under the age of 18
  - Psychosocial Rehabilitative Services
  - Medication Training and Support
  - Crisis Intervention
  - Skills Training and Development

The following services are not benefits of Texas Medicaid/STAR Health:

- Administration and supply of oral medication
- Adult and individual activities
- Biofeedback for psychological, psychophysiological, behavioral health therapy, and psychosomatic conditions
- Day-care
- Family psychotherapy without client present (procedure code 90846)
- Hypnosis
- Intensive outpatient program services (excluding substance use disorder [SUD] services)
- Marriage counseling
- Multiple family group psychotherapy (procedure code 90849)
- Music or dance therapy
- Psychiatric day treatment program services
- Psychiatric services for chronic disease, such as MR
- Psychoanalysis (procedure code 90845)
- Recreational therapy
- Services provided by a psychiatric nurse, mental health worker, psychiatric assistant, psychological assistant (excluding Master's level LPA), or licensed chemical dependency counselor (LCDC)
- Thermogenic therapy

http://www.hhsc.state.tx.us/medicaid/reports/PB9/PinkBook.pdf

Texas Medicaid and CHIP in Perspective
Ninth Edition
Texas Health and Human Services Commission January 2013

Excerpt from Chapter 6:

Behavioral Health Services
Texas Medicaid also funds behavioral health services. Behavioral health services are defined as services used to treat a mental, emotional, or chemical dependency disorder. Services include:
• Therapy by psychiatrists,
• Therapy by psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists,
• Inpatient psychiatric care in a general acute hospital,
• Inpatient care in psychiatric hospitals (for persons under age 21 and age 65 and older),
• Outpatient adolescent chemical dependency counseling by state-licensed facilities,
• Prescription medicines,
• Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbance,
• Ancillary services required to diagnose or treat behavioral health conditions,
• Care and treatment of behavioral health conditions by a primary care physician,
• Comprehensive substance use disorder benefits for adults in Medicaid including assessment, medication assisted therapy, outpatient and residential detoxification and outpatient and residential treatment, and
• Services through the Youth Empowerment Services (YES) waiver program for children and young adults under age 21 who are at risk of hospitalization because of serious emotional disturbance.

Behavioral health services are provided by therapists in private practice, physicians, private and public psychiatric hospitals, and by community mental health centers and chemical dependency treatment programs. Behavioral health services are also included in Texas managed care programs such as STAR, STAR Health, STAR+PLUS, and NorthSTAR. NorthSTAR is a behavioral health managed care program that offers a broader array of behavioral health services than other managed care programs. These additional services are paid for through savings derived from better management of services.

Link to Chapter 6:

http://www.hhsc.state.tx.us/medicaid/reports/PB9/7_PB%209th_ed_Chapter6.pdf