

South Dakota Department Of Social Services
Division of Child Protection Services
Health Care Oversight and Coordination Plan 2024



South Dakota
Department of
Social Services

Strong Families - South Dakota's Foundation and Our Future

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South Dakota Health Care Oversight and Coordination Plan

The Initial Family Assessment (IFA) is the first face to face assessment completed with a family to determine the need for protective services. The IFA employs safety concepts and decision-making methods focused on reconciling information contained within Child Protection Services (CPS) reports about alleged maltreatment and alleged threats to child safety. The IFA results in three decisions:

1. Has maltreatment occurred or is maltreatment occurring?
2. Is a child in this family subject to impending danger?
3. Is this a family who should be served by ongoing CPS?

Child functioning is the element of the IFA that captures how the child functions daily. This includes pervasive behaviors, feelings, intellect, physical capacity, temperament, vulnerability (child's ability to protect themselves), mental health, physical health, education needs, peer relations, and social and personal development. This assessment determines how the child interacts with their world on a daily basis and includes the child's physical capacity. The functioning of a nonverbal child is determined by the Family Services Specialist's observations and information gathered from caregivers.

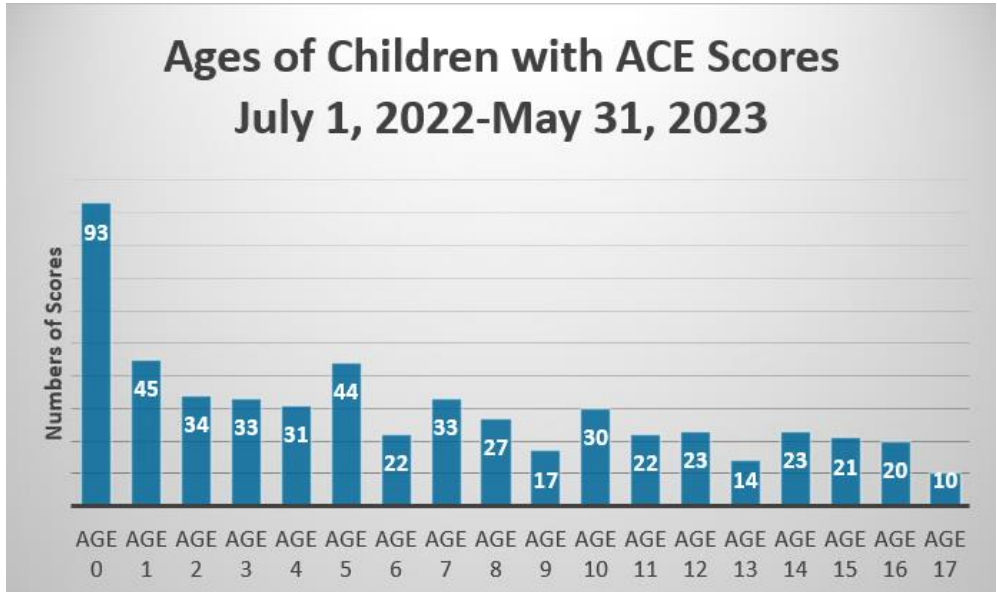
An analysis is completed at the conclusion of the Child Functioning assessment. This is the Family Services Specialist's professional opinion of how the child functions on a day-to-day basis; what makes this child unique; and the implications of child functioning on child vulnerability. The analysis is based on information gathered from the various interviews and observations by the Family Services Specialist. Further assessment of the impact of traumatic events on the child's functioning occurs through the Adverse Childhood Experience (ACE) assessment.

Survivors of repeated and severe childhood trauma generally experience a common set of problems as adults when they do not receive effective treatment. A decade-long scientific study, known as the Adverse Childhood Experiences Study, found these problems are serious and life-altering, which include increased suicidal attempts and other mental health disorders, promiscuity, use of street drugs, heavy alcohol consumption, intractable smoking, and physical health problems such as diabetes, hypertension, obesity, strokes, heart disease, certain forms of cancer, chronic lung disease and liver disease. Family Services Specialists are required to complete an ACE assessment at the conclusion of the IFA on every child who will be served with ongoing services. The results are provided through the Adverse Childhood Experience Scale after considering factors such as supports while exposed to trauma and resiliency of the child. The Family Services Specialist, Supervisor, Regional Manager, the child's parents or guardians, and current caregivers determine if the child will be referred to a trauma-informed treatment provider.

For State Fiscal Years 2023-2024 CPS renewed a contract with Visionary Mental Health based out of Pierre and Rapid City, SD for the delivery of a trauma training curriculum designed for CPS. A module specific to the ACE assessment and correlation of childhood trauma experiences and negative outcomes in adulthood is built into the curriculum. The module introduces the ACE tool. Attendees complete the tool and the discussion occurs to help better understand the link between ACE data and research supporting that childhood trauma can be impactful throughout the lifespan. Responses from CPS staff involved in the organization of the trauma training and surveys from participants at the conclusion of training have provided feedback regarding the efficacy of the change to delivery of training. Specific highlights include the cultural biases module,

incorporation of South Dakota-specific practice and procedure elements, and the enhanced effectiveness with a clinician delivering training.

With the shift of capturing ACE assessment completion from the Regional Reviews to utilization of the FACIS information system, data for July 1, 2022, to May 31, 2023, is available. There were 542 distinct ACE assessments completed during this timeframe. Graphs below identify the frequency of scores with each of the ACE scores and the ages of children who have had the ACE assessments completed. In future years information will be aligned year by year to identify trends and next steps when multiple years are available for trending.



Child Protection Services and the University of South Dakota (USD) has been partnering together on an Adverse Child Experiences (ACE) study. With early intervention and prevention efforts, the impacts of ACEs can be mitigated. Child Protection is partnering with USD to recognize ACEs as

part of a family's environment to better understand behavior and provide appropriate supports. The data collected will identify populations and regions experiencing child adversity and therefore at risk for poor health and well-being. This information can be used to identify existing supports and areas of need to promote resiliency in these communities. It can also be used to inform policy that supports protective factors (safe school environment, positive adult and peer relationships, and high cognitive skills). Specifically, this data will support service providing agencies to train their staff to address ACEs and promote resiliency within the families and children they serve. CPS has been involved with USD for the past two years in this project and shares data with USD twice each year for inclusion into their comprehensive database. CPS can request data from USD at any time.

CPS believes every child and youth who enters foster care has the right to have their well-being needs assessed and treatment plans implemented to treat identified needs. CPS uses both informal and formal assessments to assess a child's mental health/behavioral needs and physical health to determine if further professional services are needed.

Mental Health

CPS received a rating of Area Needing Improvement regarding mental/behavioral health of the child because 66% of the 38 applicable cases were rated as a Strength at the conclusion of the 2016 Child and Family Service Review (CFSR). While assessments of the mental/behavioral health of the child rated high, improvement in identifying appropriate services and assisting the child to access those services, was found to be an area or practice requiring improvement.

Additional findings of the 2016 CFSR revealed CPS was following the process of obtaining necessary psychotropic approved medications and completed the oversight on psychotropic medications. However, the documentation was not completed per policy resulting in an area of needed improvement.

The psychotropic medications policy was updated in September 2018 to coincide with the Child Case Plan process which provides specific direction to document oversight and assessment of psychotropic medications. This created one location to document that the consent and oversight process were being completed according to policy and practice standards.

Additional oversight is required for children placed at Group and Residential Facilities which includes a psychotropic medication consent form prior to starting or raising a psychotropic medication dosage. Consent and signature are required from the Family Services Specialist, consulting psychiatrist, parent, and youth ages 13 or older. Further oversight is required if the information the psychiatrist fills out falls within the Criteria Triggering Further Review. Any review that results in a finding of one or more triggers requires further review and oversight by Family Services Specialists at CPS State Office.

The following are the criteria which trigger further review:

1. Prescribed four or more concomitant psychotropic medications
2. Prescribed two or more concomitant anti-depressants
3. Prescribed two or more concomitant anti-psychotics
4. Prescribed two or more concomitant stimulant medications
5. Prescribed two or more concomitant mood stabilizer medications
6. Prescribed psychotropic medications in doses above recommended doses
7. Prescribed psychotropic medication and child is five years or younger

CPS receives a report annually from the Division of Medical Services outlining the total number of children on Medicaid, and the number of children on Medicaid in CPS custody, prescribed at least one or more psychotropic medication. The report includes information on Medicaid recipients age 21 and under who were dispensed a psychotropic drug during the previous year. The report is utilized by FACIS to provide an additional source of information to confirm the accuracy and precision of CPS data. The report allows for a comparison between the population of children in the custody of CPS to other juveniles, Medicaid recipients prescribed different psychotropic medications, and the amount. Additionally, the report provides the opportunity to compare current data to data from previous years, which provides an additional oversight and the opportunity for trend analysis.

FACIS interfaces with the State's Division of Medical Services. As part of this interface, information regarding any medications the children are prescribed display on the Pharmacy Claims tab of the Health Assessment in FACIS. This display includes the prescribing provider name, pharmacy, drug name, dosage, therapeutic class, and other items. The interface further assists the Family Services Specialist to provide proper oversight on psychotropic medications, allowing them an additional avenue to confirm any changes made to the child's medication regime.

South Dakota utilizes annual data from the Division of Medical Services to monitor trends related to utilization of psychotropic medications for youth in the custody of the Department of Social Services (DSS). South Dakota began analysis of different data points to determine reasons for the increase of children on psychotropic medications in CPS custody. This includes types of placements, types of medications prescribed, age children are prescribed psychotropic medications, and monitoring of psychotropic medications. The preliminary analysis of the data is listed below:

- From SFY22 to SFY23, the rate of all children on Medicaid prescribed psychotropic medications raised from 5.97% to 6.19%. The rate of psychotropic medication prescription for youth in CPS custody decreased in the past year, from SFY22 at 18.09% to SFY23 at 16.96%.
- Since SFY20 all children on Medicaid prescribed psychotropic medications has increased each year, whereas children in CPS custody prescribed psychotropic medications have overall decreased since SFY20; in SFY20 the rate was 17.75%, in SFY21 18.09%, and in SFY22 is 16.96%.
- The top ten medications prescribed to children in CPS custody since SFY20 are:
 - Mirtazapine: Mirtazapine is used to treat depression.
 - Aripiprazole: Prescribed to treat schizophrenia, bipolar disorder, depression, and Tourette syndrome and can also treat irritability associated with autism.
 - Escitalopram: A selective serotonin reuptake inhibitor (SSRI) prescribed to treat depression and generalized anxiety disorder.
 - Sertraline HCL: Prescribed to treat depression, obsessive-compulsive disorder, post-traumatic stress disorder, premenstrual dysphoric disorder, social anxiety disorder and panic disorder.
 - Vyvanse: A central nervous system stimulant prescribed to treat chemicals in the brain and nerves that contribute to hyperactivity and impulse control in adults and children who are at least 6 years old.
 - Trazodone: Prescribed to treat depression and can be used as a sedative as well.
 - Guanfacine HCL ER: Prescribed to treat ADHD in children who are at least 6 years old; and Fluoxetine HCL: Prescribed to treat chemicals in the brain that may become

- unbalanced and cause depression, panic, anxiety, and obsessive-compulsive symptoms.
- Three additional medications were added to the list as top prescribed, however, were not reported as top prescribed in years past; these medications are:
 - Atomoxetine HCL: Atomoxetine is used to treat Attention-Deficit Hyperactivity Disorder (ADHD) as part of a total treatment plan, including psychological, social, and other treatments. It may help to increase the ability to pay attention, concentrate, stay focused, and stop fidgeting.
 - Risperidone: Risperidone is used to treat a certain mental/mood disorder called schizophrenia; and
 - Quetiapine Fumarate: This medication is used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder).

 - The rate of prescription for each of these medications has remained fairly steady, with the rates of Mirtazapine and Aripiprazole decreasing similar intervals since SFY20. For the same time period the rate of prescription of Escitalopram has increased year after year in rate.
 - According to the Centers for Disease Control (CDC) “anxiety and depression have increased over time.
 - “Ever having been diagnosed with either anxiety or depression” among children aged 6-17 years increased from 5.4% in 2003 to 8% in 2007 and to 8.4% in 2011–2012.
 - “Ever having been diagnosed with anxiety” among children aged 6-17 years increased from 5.5% in 2007 to 6.4% in 2011–2012.
 - “Ever having been diagnosed with depression” among children aged 6-17 years did not change between 2007 (4.7%) and 2011–2012 (4.9%).”
 - Citation: <https://www.cdc.gov/childrensmentalhealth/features/anxiety-depression-children.html>.
 - Per the Utah State University, “Rates of teen anxiety and depression are on the rise; between 2003 and 2021, depression and anxiety rates in teenagers have skyrocketed from 5.4% to 20% of all U.S. teens experiencing symptoms.”
 - Citation: <https://extension.usu.edu/mentalhealth/articles/impact-of-covid-19-on-teen-anxiety-and-depression>
 - With the increase of diagnoses rates for anxiety and depression in past years and with the impact of the COVID-19 pandemic the rate of antidepressant and anti-anxiety medications is consistent with other national trends.

South Dakota completed data analysis to explore the placement settings and ages of children associated with the above psychotropic medications.

- The frequency of the prescription of psychotropic medications for youth in Intensive Residential Treatment (100%), Group Care (58%), and Residential Treatment (60%) is higher than that of children in Basic Foster Care (7%), Trial Reunification (5%), or Family Treatment Foster Care (33%).

The percentage of children prescribed psychotropic medication within the placement setting of Group Care decreased in the past year, from 84% to 58%, the same rate of prescription as FFY2019.

- There was an increase in SFY23 from FFY22 in rate of prescription of psychotropic medications for children aged 3-6 years, from 13 to 22, however in the past year this rate has gone down to 18 children.
- There has also been a reduction in the rate prescription of psychotropic medications to children in CPS custody aged 13-17 from 211 last year to 153 this year.
- The rate of prescription for children aged 7-12 did increase this year compared to last from 100 to 109.

Refer to the Attachment 1 – Psychotropic Medication Graphs section for charts and graphs of the above data.

South Dakota formed a Psychotropic Medication Workgroup comprised of members CPS and representatives from provider organizations, to review trends beginning in SFY 2021, and each year after, to determine if information reviewed regarding prescribed psychotropic medication for children relates to policy and practice by CPS. If areas in need of enhancement are identified, the workgroup will make recommendations to CPS policy and practice. The leader of the Psychotropic Medication Workgroup will report back to the Continuous Quality Improvement (CQI) Core team on their findings, progress, and next steps. The workgroup will continue to meet quarterly.

South Dakota CPS' Psychotropic Medication Workgroup completed a fidelity review to explore the documentation contained in files and alignment with policy and practice. One hundred seventy cases were reviewed by members and teams within the workgroup.

Areas assessed included in the review include:

- Placement settings
- Ages
- Diagnoses
- Assessments to support:
 - Medication
 - Diagnosis
 - Need for medication
- Current and past medications prescribed
- Medication oversight
- Consent for medication

Youth in group/residential facilities require a consent for medication form completed prior to starting a new medication, medication change, and/or dosage change. The review found out of the children who were placed in group or residential, 53% of the cases there was a consent form completed. This is a decrease from the SFY2022 review where there were 54% of children in group or residential had a consent form completed.

South Dakota CPS requires, at a minimum, monthly oversight for children in foster care who on prescribed psychotropic medication. Oversight includes discussions with the placement resources and child regarding the benefits and side effects of the medication, discussions with the prescribing doctor/psychiatrist, and reviewing the child's mental health records/progress reports. Data collected from the psychotropic medication oversight case review indicates the following:

Frequency of Medication Oversight	SFY2022	SFY2023
At least Monthly	37%	41%
Quarterly	6%	14%
Every Other Month	3%	N/A
One time in the last six months	14%	11%
Never	40%	19%
Other	N/A	11%
More than Once a Month	N/A	3%

**More than Once a Month was added in SFY2023. Other includes twice in the last six months and every other month.

Psychotropic Medication Oversight	SFY2022	SFY2023
Discussions with the placement resource regarding benefits of the medication(s)	12%	39%
Discussions with the child regarding benefits of the medication(s)	19%	45%
Discussions with the placement resource regarding side effects of the medication(s)	8%	34%
Discussions with the child regarding side effects of the medication(s)	18%	33%
Discussions with the prescribing doctor/psychiatrist	2%	10%
Review of the child's mental health records/progress reports	19%	51%
There was no oversight located in documentation	23%	21%
Other	N/A	7%

**Other was added in SFY2023. Other includes documentation that records were reviewed, but none were found in the file.

Refer to the Attachment 2 – Psychotropic Medication Workgroup Graphs section for charts and graphs of the above data.

As stated previously, the Child Case Plan contains the current status of the child’s mental health. The Child Case Plan is reviewed by the Supervisor with the Family Services Specialist for accurate completion and quality data. The following items are included for focus of the Mental Health section:

- Dates of evaluations and provider names
- Current diagnoses
- Current medications and therapist
- Strengths and challenges
- Progress

CPS also monitors proper oversight on psychotropic medications, sufficient assessment of mental health needs and services through Regional Reviews. Regional Reviews are completed one time a year in each region in South Dakota.

Children and youth who receive Child Protection Services have typically experienced or been exposed to traumatic events such as physical abuse, sexual abuse, chronic neglect, sudden or violent loss of or separation from a loved one, domestic violence, and/or community violence. These children often have emotional, behavioral, social, and mental health challenges that require special care and treatment. This has significant implications for the delivery of services.

Family Services Specialists must be both trauma-aware and trauma-informed to address the multiple challenges traumatized children and their families bring with them when they enter the system. A trauma-aware and trauma-informed staff seeks to change the paradigm from one which asks, “What’s wrong with you?” to one which asks, “What has happened to you?” Trauma-informed care is an approach to engaging individuals with histories of trauma which recognizes the presence of trauma symptoms and acknowledges the role trauma has played in their lives. The child welfare system must promote healing environments through embracing key trauma-informed principles of safety, trust, collaboration, choice, and empowerment. In addition, it is important to identify services within the community treatment providers that are trauma informed.

Trauma-informed care is an established practice which can dramatically improve the outcomes for children, youth, and their families. Trauma-informed practice, which means the responses by all members of the child welfare system to traumatized children, youth, and families, includes all the following elements:

- A child-focused, family-centered, gender-specific and culturally sensitive, strength-based approach.
- Highly individualized assessment and care which identifies and acts on the child/caregiver/family and social/environmental risk and protective factors.
- A relationship which is characterized by respect, dignity, compassion, listening and being present in the moment and validation.
- A relationship which is based on a partnership with families, supports families and promotes empowerment.
- A recognition and appreciation of the high prevalence of traumatic experiences by those children, youth and families served.
- An understanding of the profound neurological, biological, psychological, cognitive, and social effects of trauma and violence on the child and family.
- Planned, purposeful, anticipatory, and proactive actions which reduce or eliminate the potential for harm or re-traumatizing.
- An inclusive, collaborative approach with community partners involved in the child and caregiver’s lives.

The intent of being trauma-informed is to promote a system that recognizes, understands, and appropriately responds to trauma and its’ side effects on children and their families. To achieve the goals of safety, permanency and well-being within CPS, all activities by the Family Services Specialist are focused on strengthening the family, promoting resiliency, enhancing physical, emotional, and social well-being, including healing trauma wounds, and reducing or eliminating system-level activities which may further harm or re-traumatize children and their families.

The Family First Prevention and Services Act (FFPSA) requires Qualified Residential Treatment Providers to:

- Have a trauma informed treatment model.
- Have registered or licensed nursing and other licensed clinical staff onsite, consistent with the Qualified Residential Treatment Program (QRTP) treatment model.
- Facilitates outreach and engagement of the child’s family in the child’s treatment plan.

- Provides discharge planning and family-based aftercare supports for at least 6 months.
- Be licensed by the state and accredited.

The Department of Social Services has collaborated with these providers, and all have achieved and maintained accreditation.

Children's health needs are documented on the Health Assessment screen in FACIS, the State's Comprehensive Child Welfare Information System (CCWIS). These assessment screens capture necessary information regarding the child's health status. In addition, diagnosed conditions being monitored in the Adoption and Foster Care Analysis and Reporting System (AFCARS) are documented in the Diagnosed Conditions area on the AFCARS screen.

From the time the child is assigned to receive services (out of home), the Family Services Specialist has 60 days to complete the child assessment in FACIS. If no information is updated on the screen for 180 days, the Family Services Specialist's caseload compliance report will report the inactivity; the lack of compliance is also automatically displayed to the Supervisor as an area of non-compliance. The expectation is for information to be updated minimally every six months. The Health Assessment is the focus for this oversight.

FACIS captures the following information regarding mental health:

- Requests for health records including when records were received.
- Mental health evaluations and appointments.
- Trauma treatment referrals and progress report information.
- Comment field (captures special conditions of a child not reflected on the Diagnosed Conditions area of the AFCARS screen).

CPS completes a Child Case Plan within 60 days from the date a child enters care. The Child Case Plan is a formalized assessment completed through collaboration with the child, parents, placement resources, service providers, and Family Services Specialist.

FACIS captures mental health appointments, evaluations, and progress in an internal system that is only available to CPS staff. However, it's important for youth, parents, and placement resources to be aware of mental health information. Revisions to the Child Case Plan, completed in August of 2017, captures the child's health assessment information and autogenerates into the Child Case Plan, ensuring current and accurate information is available to the child, parent and placement resource when provided in the Child Case Plan.

Another FFPSA-related enhancement was the development of a relationship with a Community Mental Health Provider to conduct QRTP assessments as an external entity, related to utilization of IV-E funding to support a placement in a QRTP setting.

Dakota Counseling Institute (DCI) of Mitchell, SD continues to conduct these assessments on an ongoing basis. DCI utilizes the Child and Adolescent Needs and Strengths (CANS) Assessment for youth prior to entry or within 30 days of entry to a QRTP setting. A court approval form was developed collaboratively and shared as a tool to assist in documentation of court approval for QRTP placement. Training on this process was provided to each CPS region throughout the state, the Court Improvement Program, tribal judicial partners, tribal IV-E contract sites, providers, and documents prepared to facilitate ongoing training efforts. FACIS modules have been developed to track children's stays in QRTP settings to assure approval of continued stays at required intervals.

Physical Health

South Dakota CPS completed Round 3 of the CFSR in September 2016. CPS received a rating of Area Needing Improvement for physical health needs of the child as only 76% of applicable cases were found to be a strength with improvements required in the assessment of needs and services provided to meet the identified needs.

CPS requires each child to receive a health care screening within 30 days of entering care. CPS also requires a child to receive a dental exam by a dentist by their first birthday or first tooth, whichever arrives first. CPS follows the Well-Child Check-ups schedule for children in CPS placement. These check-ups assist CPS staff and placement resources to manage ongoing routine screenings and to monitor ongoing health needs of the child. The appointments are documented in the FACIS Health Assessment screens. The Well-Child Check guidelines are followed for children in custody and provide CPS staff and placement resources with a colorful and easily interpreted chart to ensure screenings are completed. Well-child visits are conducted in accordance with the American Academy of Pediatrics Bright Futures recommendation for preventative pediatric care. South Dakota Medicaid mails the placement resource a letter during the month of the child's birthday to remind them to schedule a well-child check-up and other services, such as teeth cleaning and a vision exam. Refer to the charts for health screenings and immunizations.

RECOMMENDED IMMUNIZATION SCHEDULE														
Vaccine	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years	11-12 years	16 years	
HepB (Hepatitis B)	1 dose	1 dose			1 dose									
RV (Rotavirus)			1 dose	1 dose	1 dose									
DTap (Tetanus, diphtheria, pertussis)			1 dose	1 dose	1 dose		1 dose				1 dose	1 dose		
Hib (Haemophilus influenzae type b)			1 dose	1 dose	1 dose	1 dose								
PCV (Pneumococcal)			1 dose	1 dose	1 dose	1 dose								
IPV (Polio)			1 dose	1 dose	1 dose						1 dose			
Flu (Influenza)					2 doses in first year, then 1 dose annually									
MMR (Measles, Mumps, Rubella)						1 dose					1 dose			
Varicella (Chickenpox)						1 dose					1 dose			
HepA (Hepatitis A)						2 doses								
MCV4 (Meningococcal)												1 dose	1 dose	
HPV (Human Papillomavirus)												2 doses		

Well Visit & Immunization ROAD MAP

**0-18+
Years**



Family Services Specialists complete Permanency and Well-Being Certification training; they are trained to assess a child's physical health needs, including dental and vision and how to utilize the tools from the Division of Medical Services and Child Protection Services to assess and provide services to meet physical health needs. This includes providing proper oversight of a child's physical health needs and medications. Through the Division of Medical Services, the Family Services Specialist utilizes the chart above and are encouraged to provide the charts to placement resources. The Family Services Specialists must request immunization records, typically from the local Women, Infant, Children (WIC) office or the child's primary health care provider, to ensure children are up to date with their immunizations. If a child is behind on immunizations when entering custody, the Family Services Specialist discusses this with the parent, the placement resource, and medical professionals to develop a plan to bring immunizations up to date. Children's health needs are documented on the Health Assessment within FACIS. The assessment screens capture necessary information regarding the child's health status. The earlier explanation of diagnosed conditions, AFCARS, and interface with Division of Medical Services as stated in the Mental Health section also apply to the Physical Health section.

As noted previously, CPS allows 60 days from a child entering custody for the completion of the child assessment. If an assessment is not completed within 180 days, compliance reports alert the Family Services Specialist and their Supervisor. The expectation is for information to be updated minimally every six months in FACIS. The Health Assessment is the focus for this oversight.

The screen captures the following physical health information:

- Immunization status
- Requests for Health Records including when records were received
- Referral to Birth to Three program
- Exams (captures type and provider information)
- Comment field (captures special conditions of a child not reflected on the Diagnosed Conditions AFCARS screen, e.g., chronic ear infections)

The Child Case Plan captures a child's physical health, including dental and vision strength and needs. Physical health strengths and needs in the Child Case Plan are determined by observations of the child, discussions with the child, placement resource, parents, medical professionals, and review of medical records. FACIS captures physical health appointments, evaluations, and records requests; this information is only available to CPS staff. However, it's important for the child, parents, and placement resources to be aware of physical health information. Revisions to the Child Case Plan, completed in August 2017, enhanced the information captured in the child's health assessment which autogenerates into the Child Case Plan, ensuring current and accurate information is available to the child, parent and placement resources when they are provided a copy of the Child Case Plan. During the Case Plan preparation, the Family Services Specialist requests records from any relevant medical provider who provides care to the child. When records are received, the receipt is documented in the Health Assessment area within FACIS. The Family Services Specialist reviews the records as part of the Case Plan evaluation process. There is a prompt in the Child Case Plan reminding the Family Services Specialist to review medical and mental health records. The Family Services Specialist must verify the records review on the Child Case Plan.

The placement resource and child's parents are expected to be invited to attend appointments if there are no threats to safety. Often the placement resource sets appointments and takes the child to these appointments. At the end of the appointment, the Family Services Specialist,

placement resource and/or parents are provided a summary of the appointment. If the placement resource and/or parent did not attend the appointment, the Family Services Specialist shares the records with them as soon as possible. At a minimum, the information is shared during the next Case Plan evaluation. CPS is exploring further mechanisms to verify placement resources receive the child's records.

CPS requires all children entering State custody to have a physical exam during the first 30 days of custody. Subsequent well-child exams must be scheduled according to the Well-Child Care Recommended Schedule. At minimum, children in CPS custody must have one annual well-child exam per year. CPS conducted a review of all children in CPS custody over 30 days to determine if annual well-child exams are occurring as directed in policy.

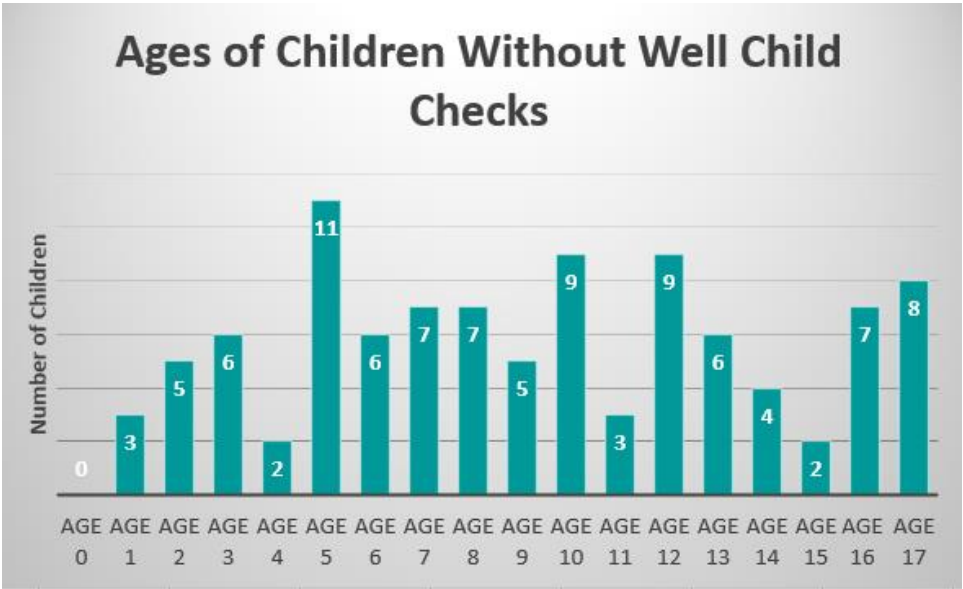
South Dakota Medicaid provided CPS with a list of 417 children in CPS custody over 30 days between January 1, 2022, and December 31, 2022, with no well-child exam billed to Medicaid in this timeframe. Given the requirement to maintain Medicaid for children due to the pandemic, 298 children remained on the list for further review. CPS completed a review of the 298 children to determine if the child received a comprehensive medical assessment within this timeframe. In the previous year's reporting, there were a total of 60 well-child visits not completed compared to the current reporting of 100 children who had no well-child check within the year, this is an increase of 40 individuals to last year. These numbers equate to 5.9% of the total children in custody in 2022 without a well-child visit, an increase from the year prior. CPS completed a case review of the 298 children to determine if the child received a comprehensive medical assessment within this timeframe. If documentation of a medical assessment was found, the reviewer determined if the comprehensive medical assessment was billed to another agency other than Medicaid or combined with another medical evaluation not coded as "well-child visit".

Below are the outcomes of the cases reviewed:

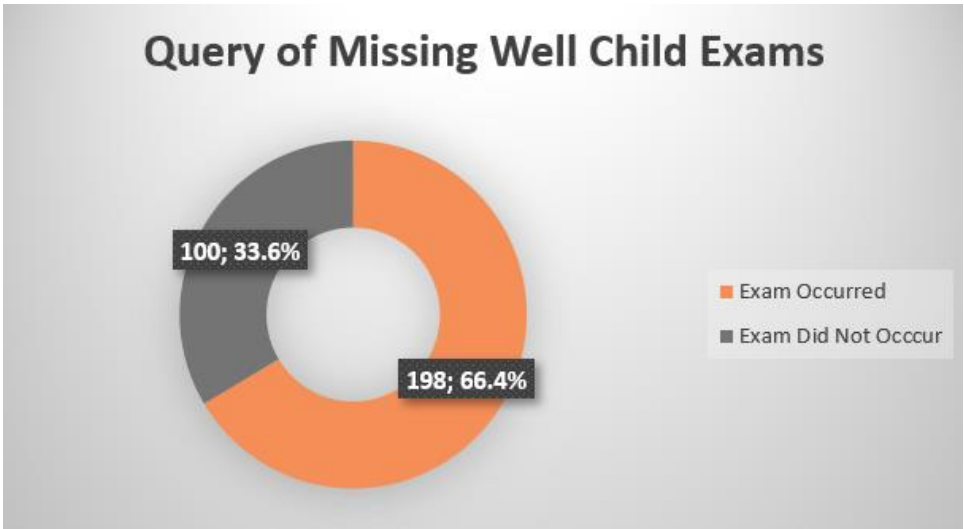
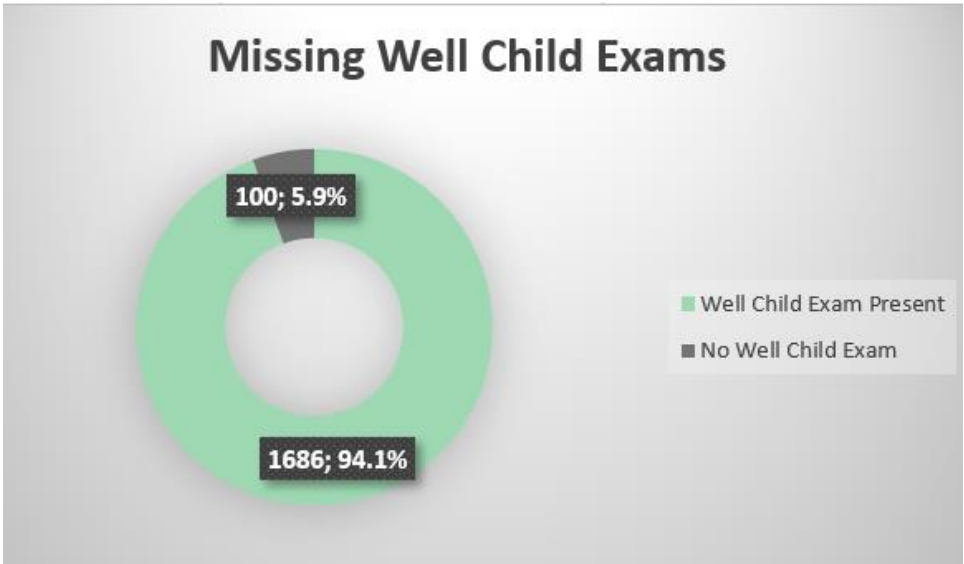
Well-Child Visit Outcome	Number of Child Cases
Well-child visit was combined with another comprehensive medical exam billed to Medicaid (ex: emergency medical evaluation, ongoing care with a relevant Specialist, or forensic interview including physical).	5
Well-child visit was completed and billed to another agency other than SD Medicaid (CPS, Indian Health Services, Private Insurance, etc.)	25
Well-child visit was not completed as child was in custody less than 30 days during time period.	14
Child was listed twice with a different name. Duplicate information.	0

Well-child visit was not completed.	100
Child was considered to be a runaway during the majority of the year.	2
Well-child visit was completed out of state	0
In Department of Corrections Placement	3

During 2022 as the COVID-19 pandemic continued to impact health care services across the world. South Dakota providers utilized telemedicine where appropriate, but most medical providers largely stayed open throughout the remainder of the pandemic while incorporating safety precautions. Comparing previous year data to current year data two children were on runaway status this year, compared to zero last year. In the previous year’s reporting, there were a total of 60 well-child visits not completed compared to the current reporting of 100 children who had no well-child check within the year; this is an increase. A graph has been included outlining the ages of the children without well-child visits. There were no children this year with a well-child visit completed out of state and but three children this year, compared to six last year, who were concurrently in Department of Corrections placement while in CPS custody; this data will be explored further as it’s probable exams may have been completed in the facility and not billed to Medicaid or results shared with CPS.



The below graphs reflect well-child exams not completed of children in CPS custody and the breakdown of the detailed review of the initial impression of exams not completed.



The Regional Managers, Supervisors, and Family Services Specialists were provided the names of children who did not have a well-child visit in 2022 to provide added awareness and accountability related to ensuring well-child visits are completed according to the Well-Child Care Recommended Schedule. The information is shared with the Permanency Well-Being training team who provides training to newly hired Family Services Specialists related to the assessment of medical needs for children in CPS custody. The training team will adjust curriculum as needed. CPS plans to continue collaboration with SD Medicaid for ongoing review of children in CPS custody without a well-child visit to ensure children are receiving timely and scheduled well-childcare on an annual basis. A new case review will be requested in February 2024. Child cases from 2023 will be reviewed and analyzed at that time to determine if the number of children without a well-child visit increase, decreases, or stays the same and a decision will be made if further action is needed.

Regional Reviews are completed annually in each CPS region within South Dakota. The reviews are conducted to evaluate compliance with State policy regarding proper oversight of prescription

medications as well as to determine if there was an adequate assessment of a child's physical health needs and services. Regional Reviews provide data and trends identifying the opportunities for future enhancements in providing for children's physical needs.

Children in the custody of CPS who reside in a foster or kinship home are eligible for The Division of Medical Services Health Homes program. Health Homes are part of a person-centered system of care that achieves improved outcomes for recipients and better services and value for State Medicaid programs. Health Homes is a method of delivering enhanced health care services which promises better patient experience and better results than traditional care. Health Homes have many characteristics of the Patient-Centered Medical Home but is customized to meet the specific needs of recipients of Medicaid who have chronic medical conditions or behavioral health conditions.

Health Homes must provide six federally mandated Core Services:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Patient and Family Support
- Referral to Community and Support Services

Health Homes are encouraged to utilize health information technology to more efficiently and effectively coordinate the care of Health Home patients. Through the provision of the six Core Services, the Health Home initiative aims to reduce inpatient hospitalization and emergency room visits, increase the integration between physical and behavioral health services, and enhance transitional care between institutions and the community.

Resource parents are provided information on the availability of the Health Home program. Ultimately, the resource parent, in consultation with the Family Services Specialist, makes the determination if they will participate in the program. CPS advocates for all children in custody who have complex medical needs or behavioral health conditions to take advantage of this service.

Psychiatric Residential Treatment Facilities (PRTF)

CPS seeks active oversight and confirmation of the determination of need prior to a child being placed in a psychiatric residential treatment facility (PRTF). CPS' partners in these safeguards are the State Review Team (SRT) and the South Dakota Foundation for Medical Care, formerly known as Peer Review Organization (PRO). The SRT is comprised of representatives from the Departments of Social Services, Corrections, Human Services, and Education who meet weekly to review each referral for PRTF. Each member of the SRT has an opportunity to ask questions, discuss alternatives to PRTF, and provide feedback. If the recommendation is for PRTF level of care, the SRT Facilitator notifies the South Dakota Foundation for Medical Care Team for final determination of medical necessity.

The Division of Medical Services contracts with the South Dakota Foundation for Medical Care, to serve as the certification team. Physicians are Board Certified in child/adolescent psychiatry. The nurse is certified by the American Nurses Credentialing Center in psychiatric and mental health nursing, addictions nursing, and managed care nursing. Medicaid (Title XIX) pays the treatment costs after approval by the team. The diagnosis supporting the need for placement in a PRTF is confirmed by the team to ensure no child is placed in a PRTF due to inaccurate diagnosis.

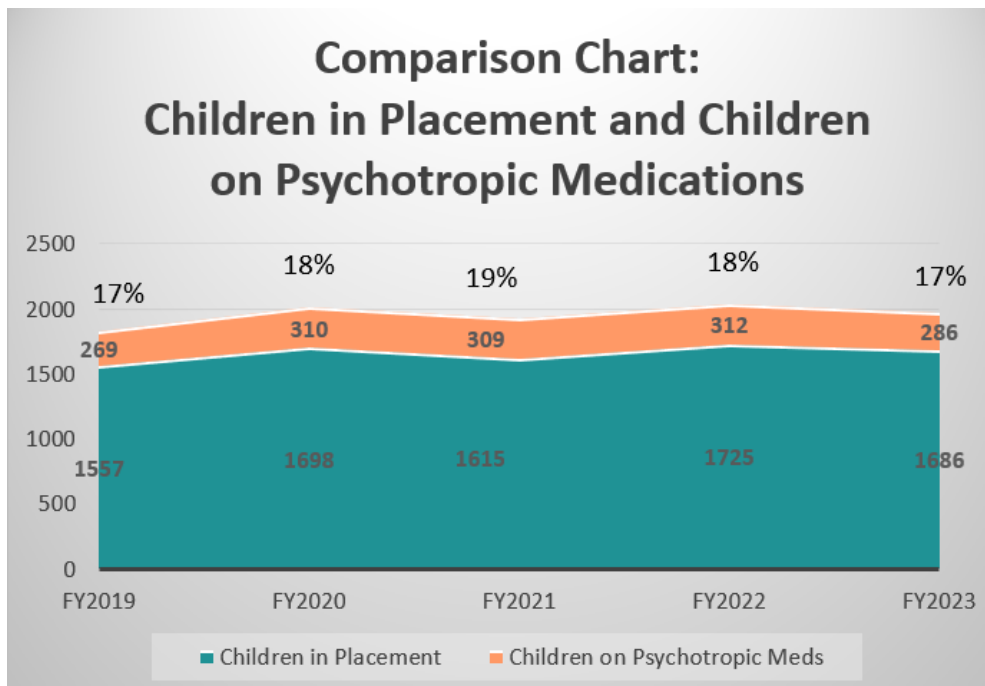
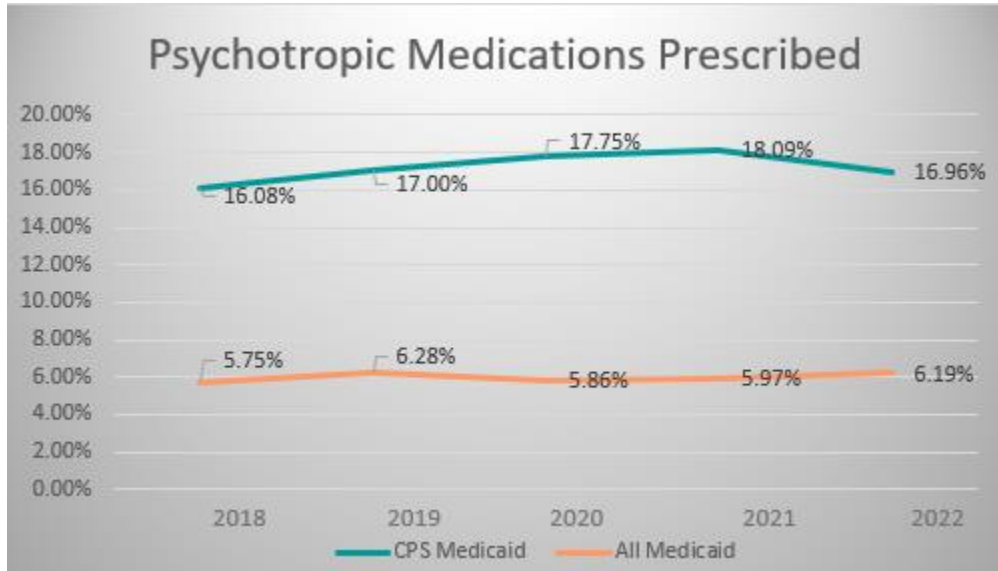
Prior to the acceptance of a referral for residential treatment facility, no child is to be placed in a PRTF until Medicaid (Title XIX) approval has been received from the South Dakota Foundation for Medical Care with a specific length of stay and oversight, and authorization of requests to extend treatment stays based on progress toward treatment goals.

Child Advocacy Centers

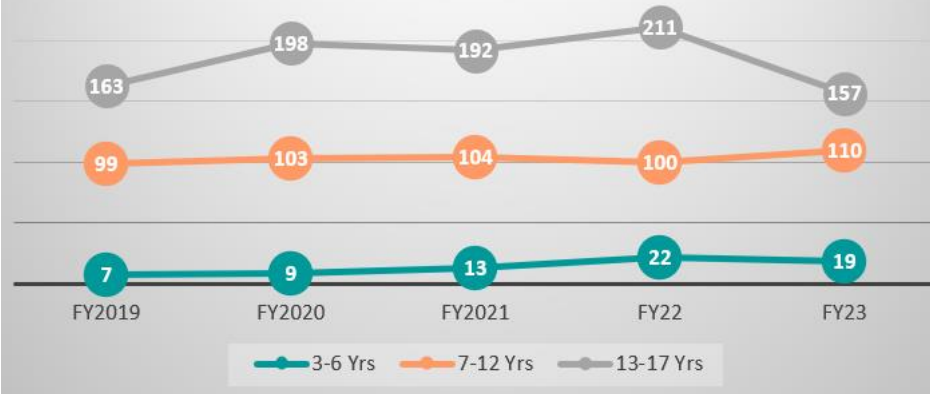
There are three accredited Child Advocacy Centers across South Dakota: 1) Children's Home Child Advocacy Center in Rapid City; 2) Child's Voice in Sioux Falls; and 3) Central South Dakota Child Assessment Center in Pierre. Oglala Lakota Children's Justice Center in Pine Ridge also serves as a child advocacy center. The Child Advocacy Centers are child-focused centers that have a multidisciplinary team providing confidential services for children who have allegedly been mistreated. The Child Advocacy Centers have professionals specifically trained to interview a child or provide medical exams for the child. Representatives from many disciplines, including law enforcement, child protection, prosecution, mental health, medical and victim advocacy, and child advocacy, work together to conduct interviews and make team decisions about the investigation, treatment, management, and prosecution of child abuse cases. The Child Advocacy Centers provide crisis intervention, victim assistance, and referrals for services regarding aftercare for alleged victims and their family. They also provide training, support, technical assistance, and leadership on a statewide level to communities throughout South Dakota.

A community effort to meet the health care needs of children in foster care includes use of the Foster Care Clinic. Children in CPS custody have comprehensive medical exams completed by a medical team that specializes in child abuse and maltreatment. In Sioux Falls, exams are completed in partnership with the Sanford Children's Clinic. In Pierre, they are completed in partnership with Avera St. Mary's Hospital. The exams review medical history, and an assessment of the child's development is completed. Referrals are made for mental health, medical, dental, vision or hearing, if needed. Appointments at the Foster Care Clinic are completed within 30 days of children placed in custody.

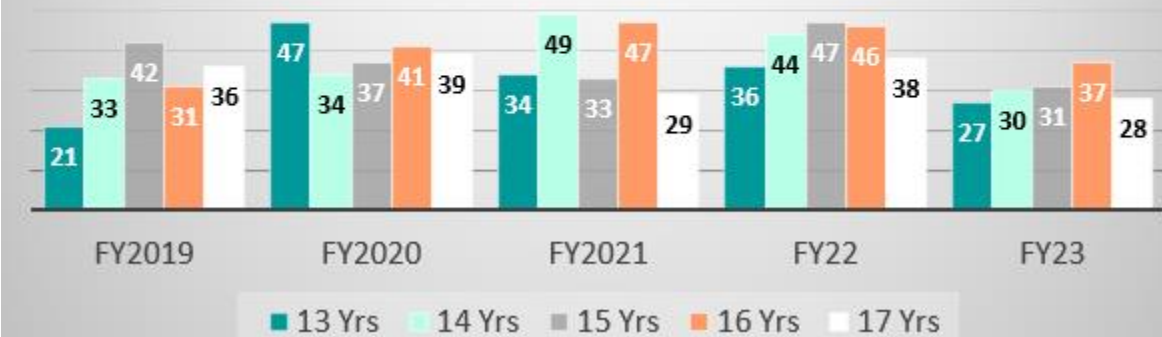
Attachment 1- Psychotropic Medication Graphs



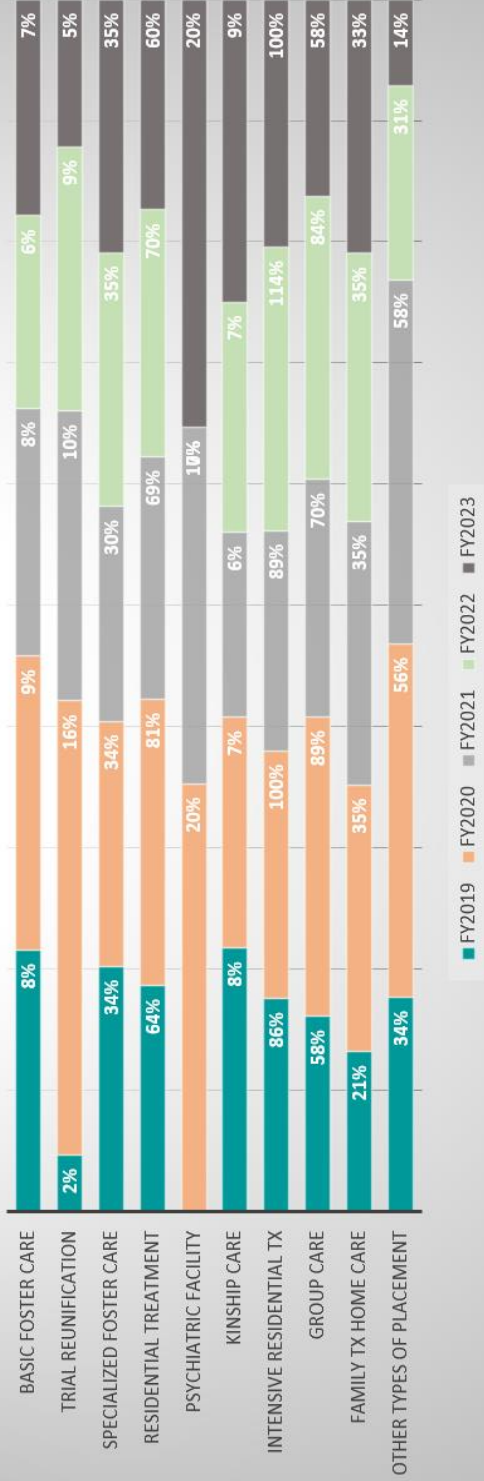
Children on Psychotropic Medications by Age



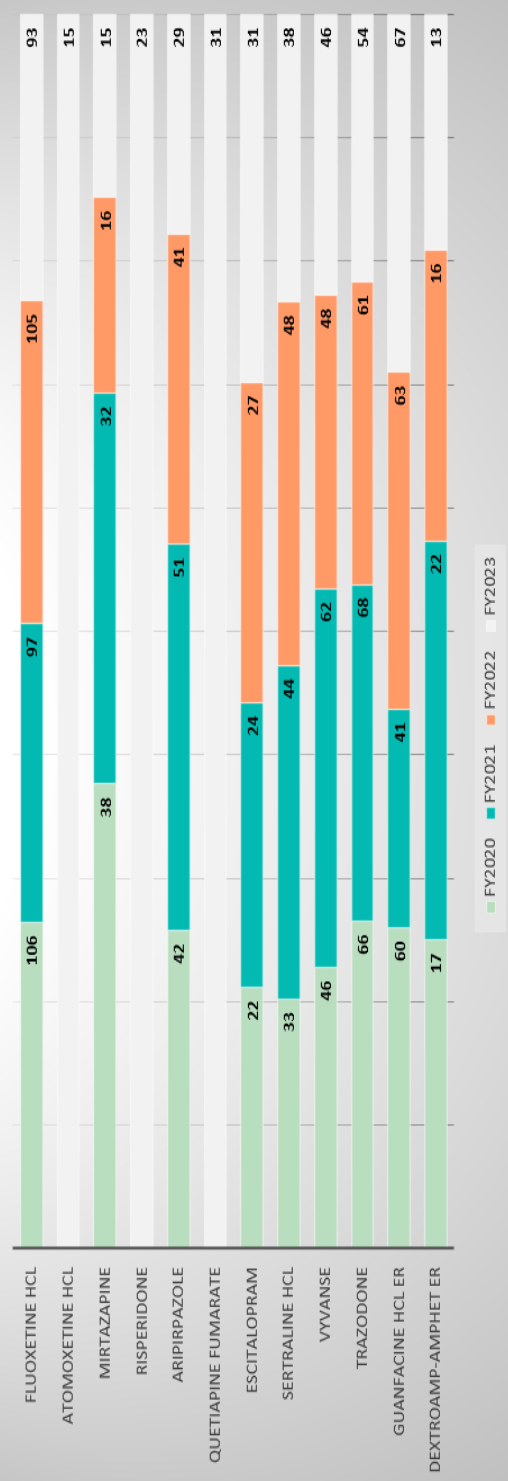
Children Aged 13-17 on Psychotropic Medication



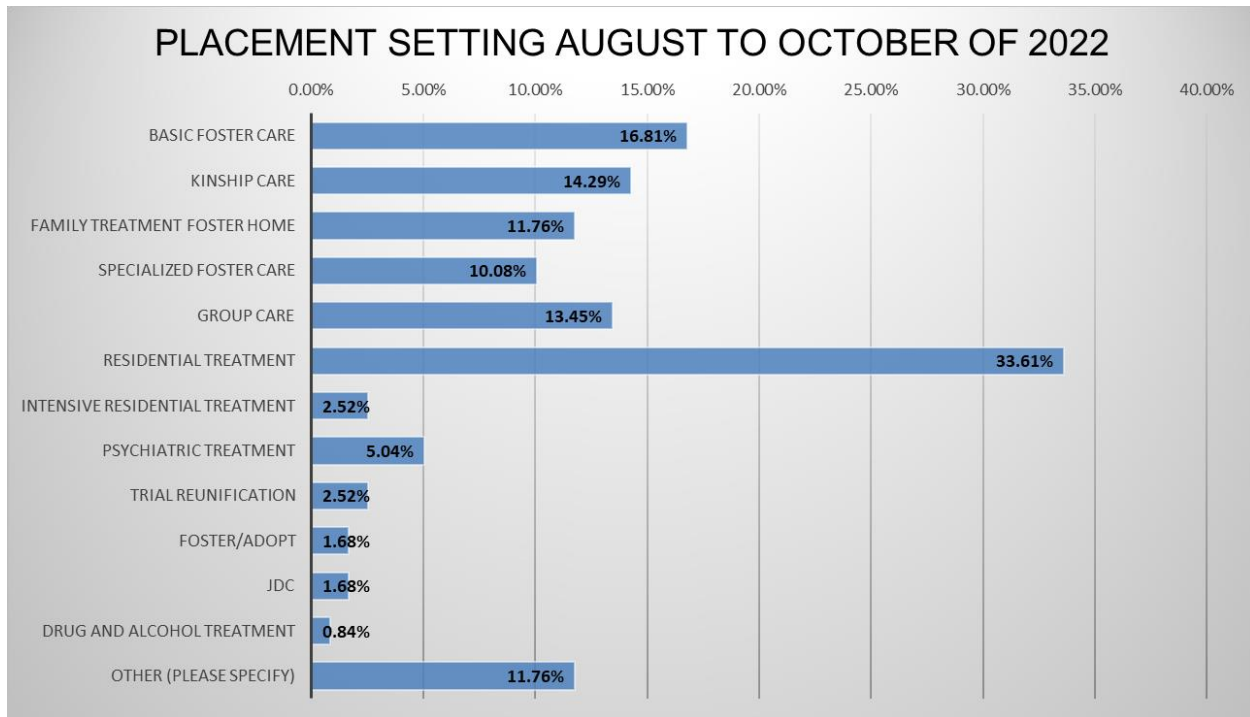
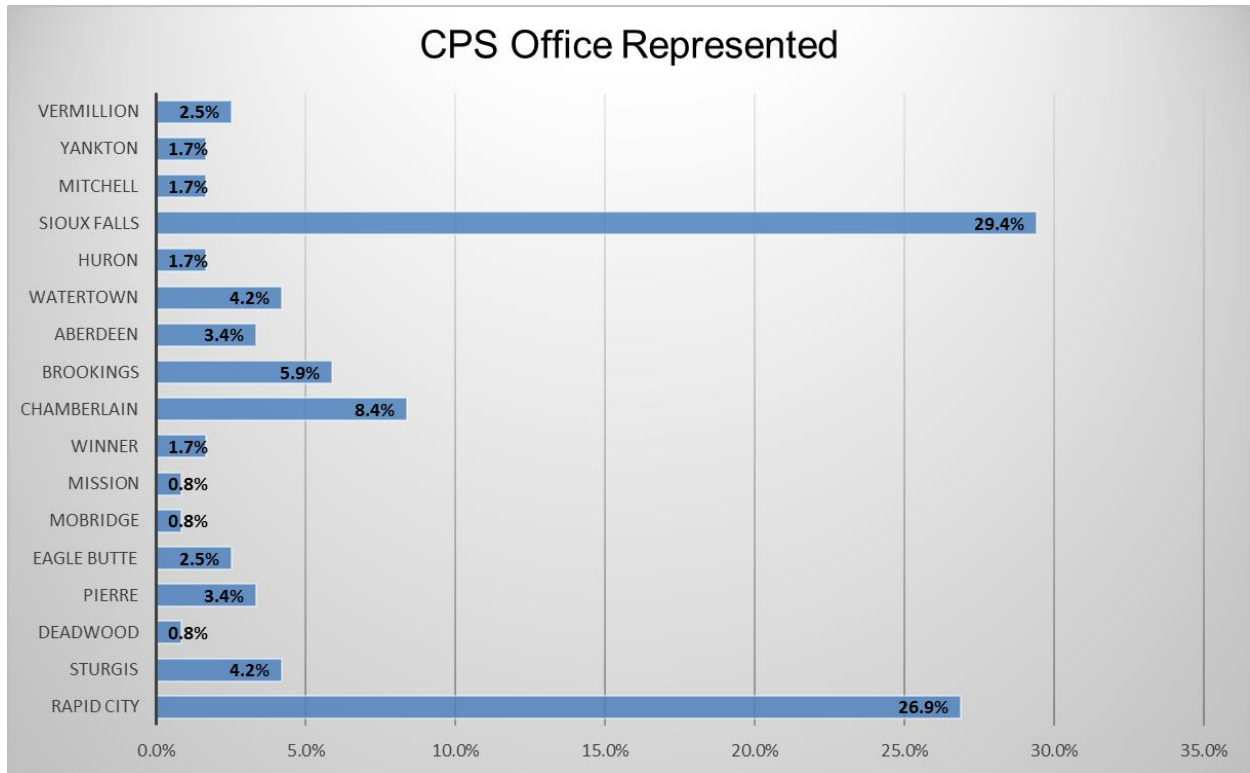
Children on Psychotropic Medications by Placement



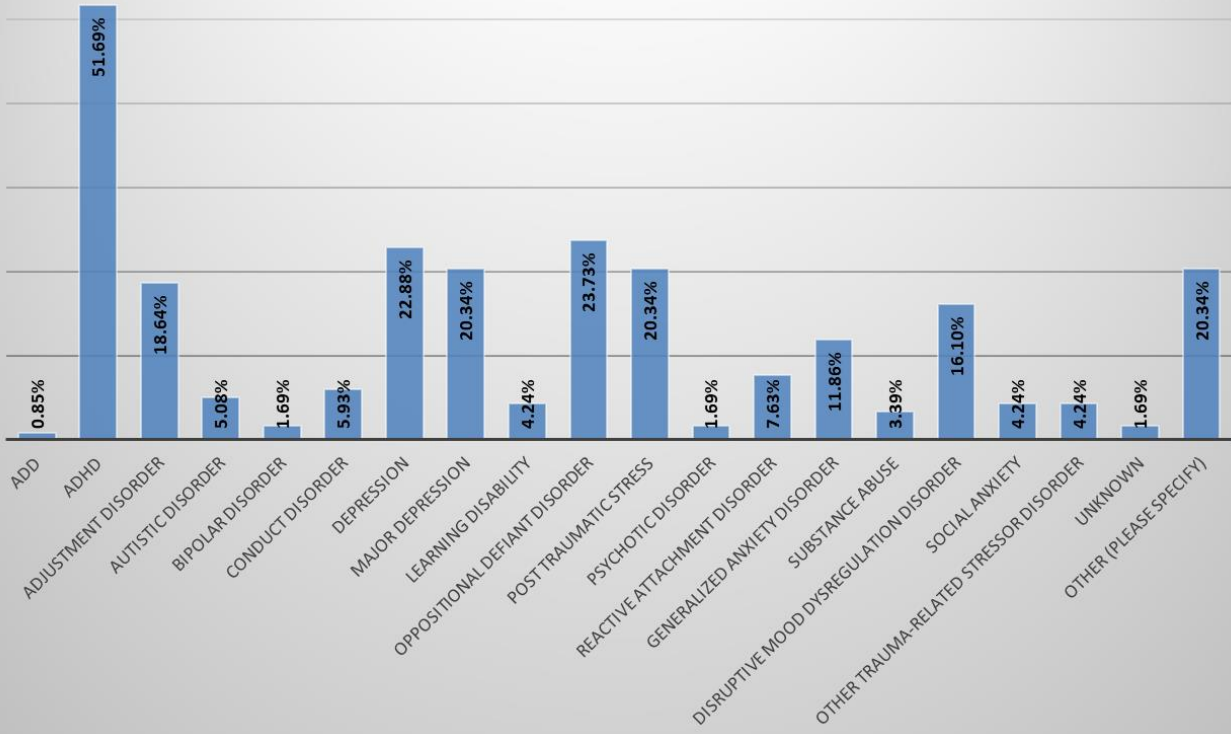
Type of Psychotropic Medication Children in CPS Custody are Prescribed



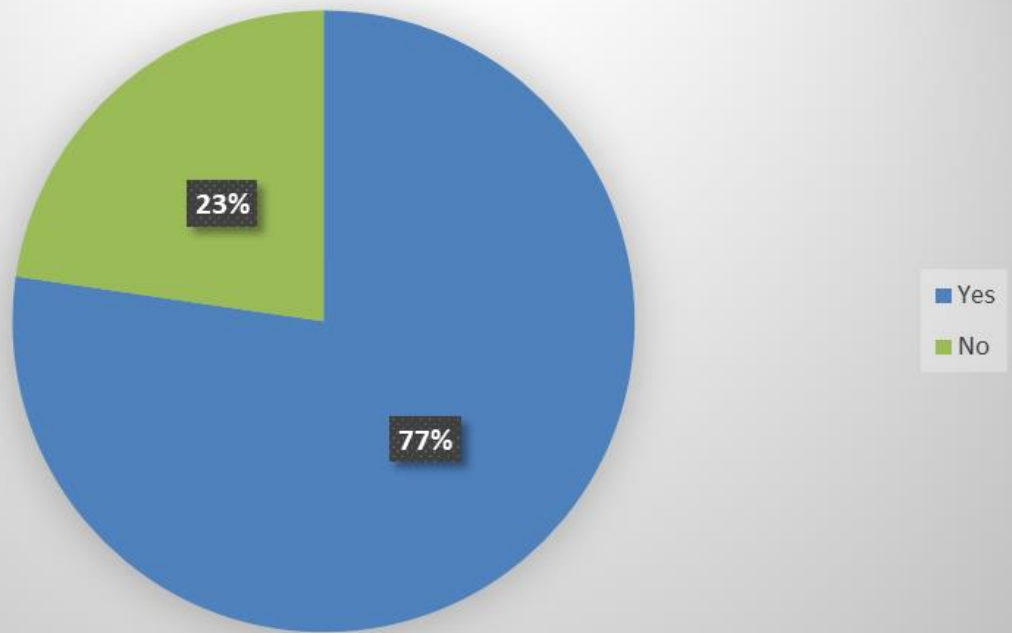
Attachment 2 - Psychotropic Medication Workgroup Graphs



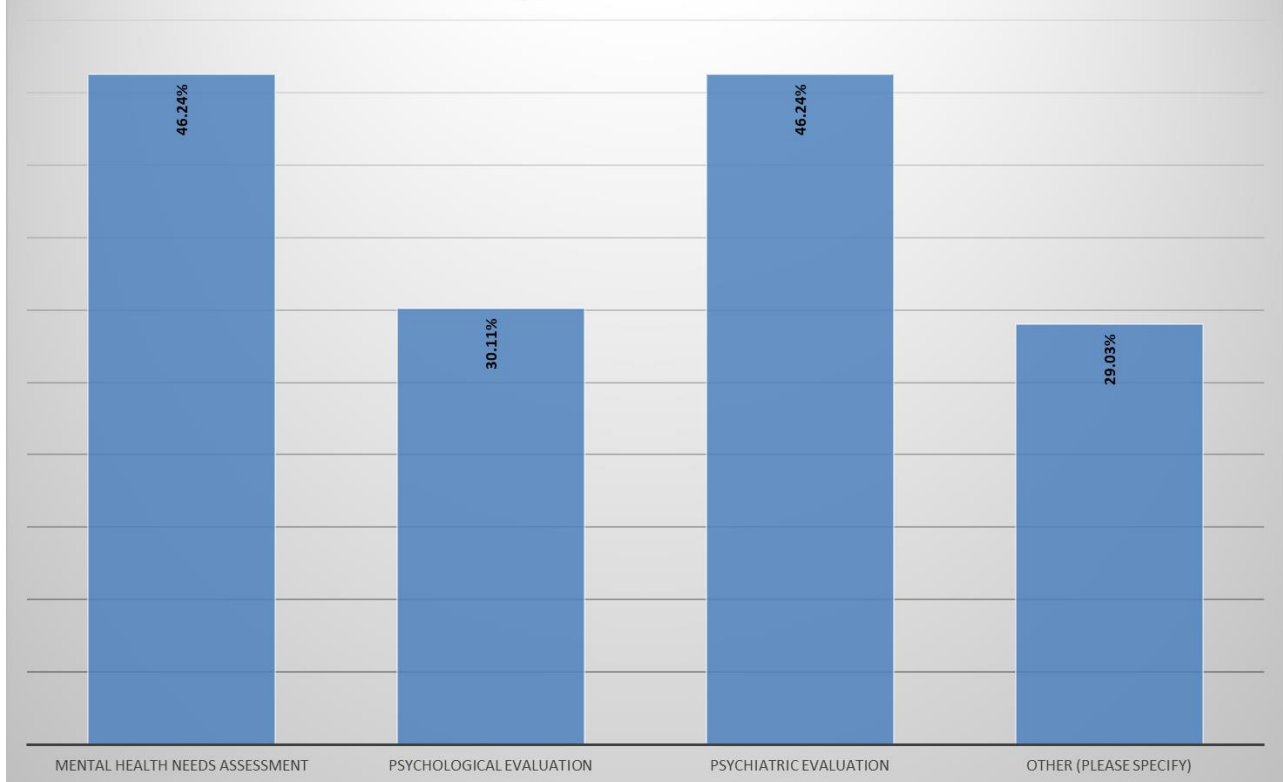
CHILD'S DIAGNOSIS



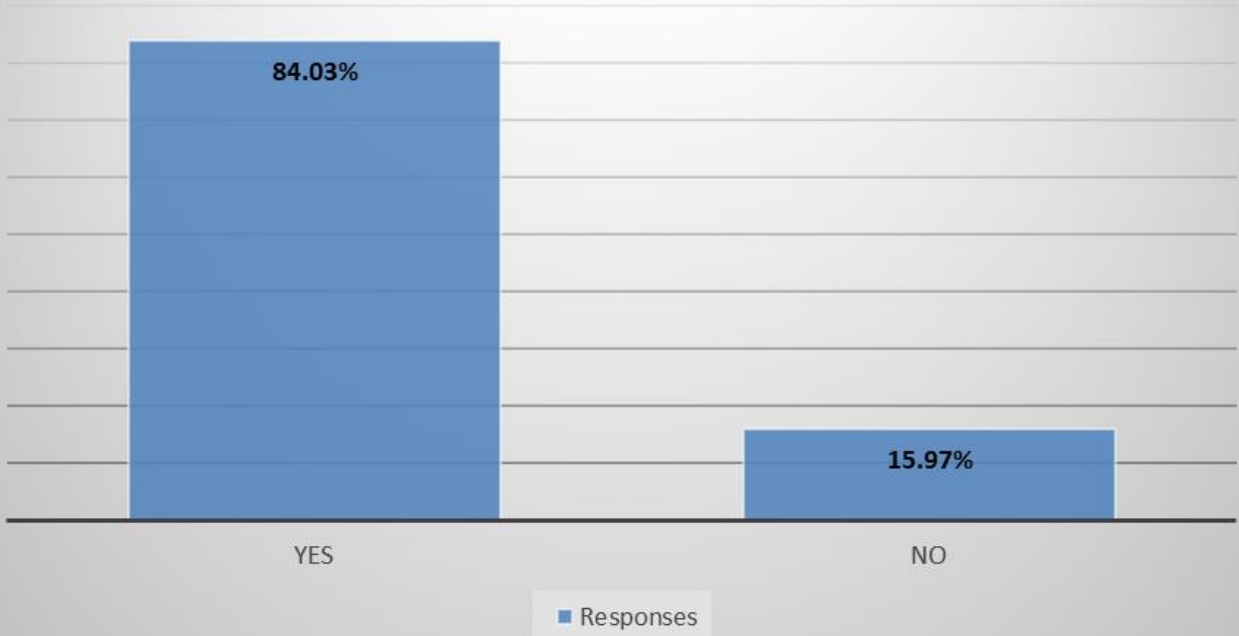
Assessment in File to Support Diagnosis



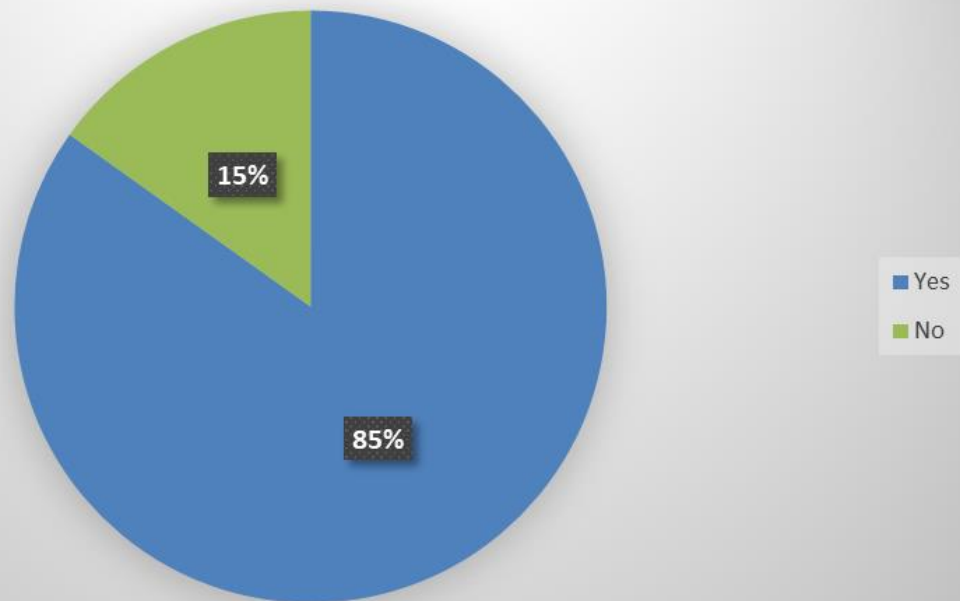
Type of Assessment



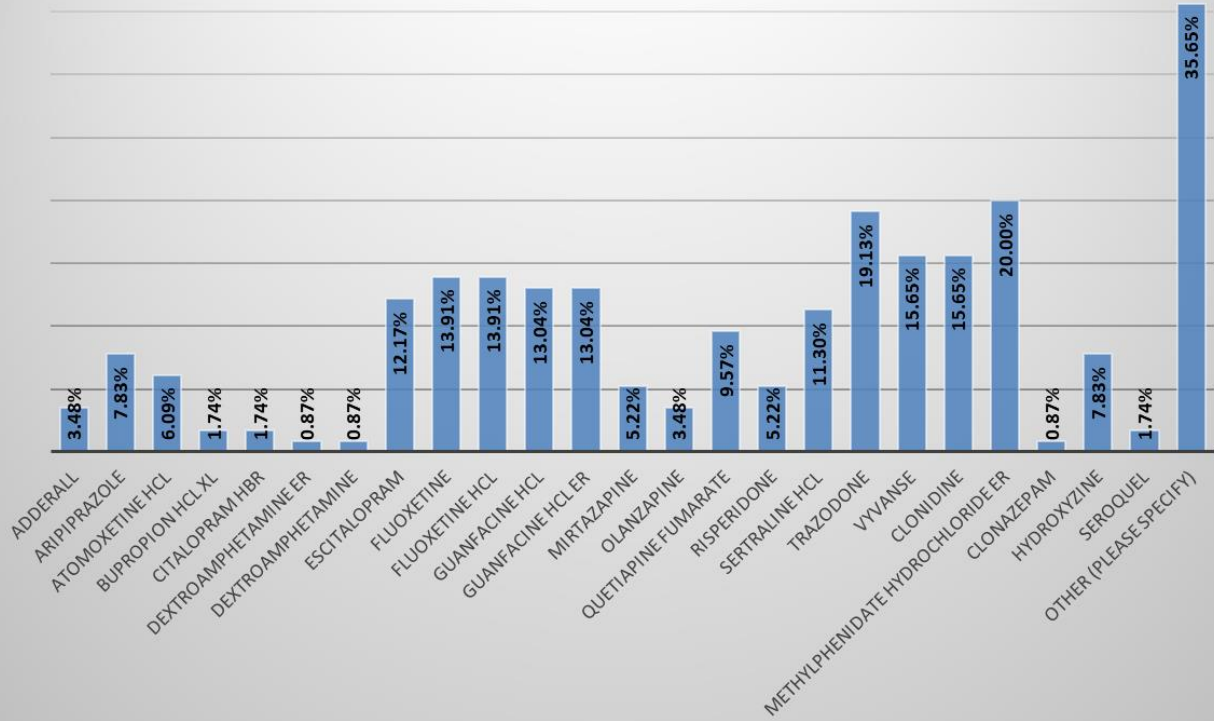
Information to Support Diagnosis in File



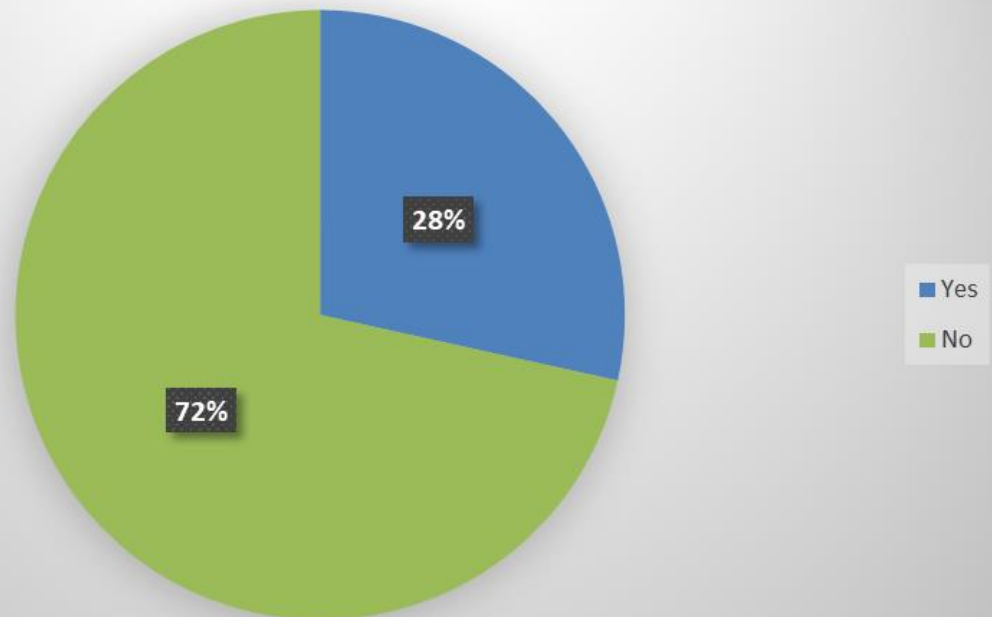
Need for Medication Documented in File



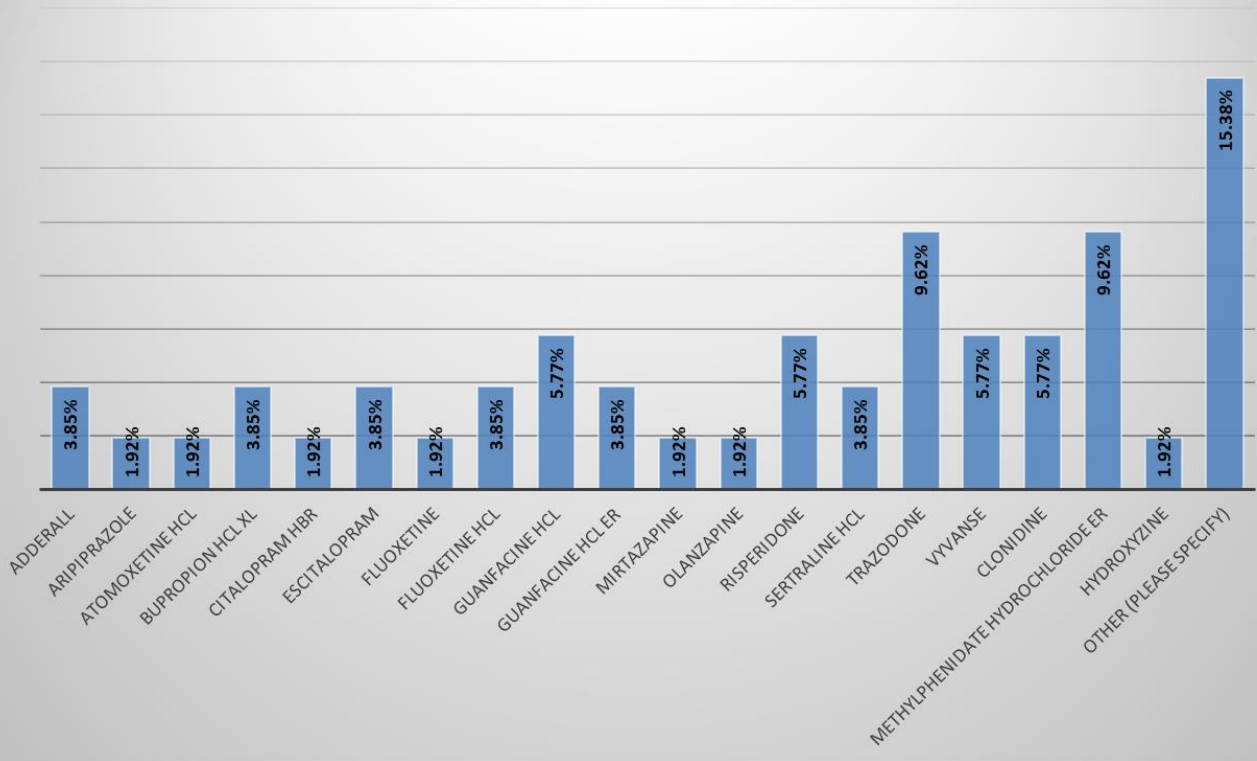
Medication Currently Prescribed



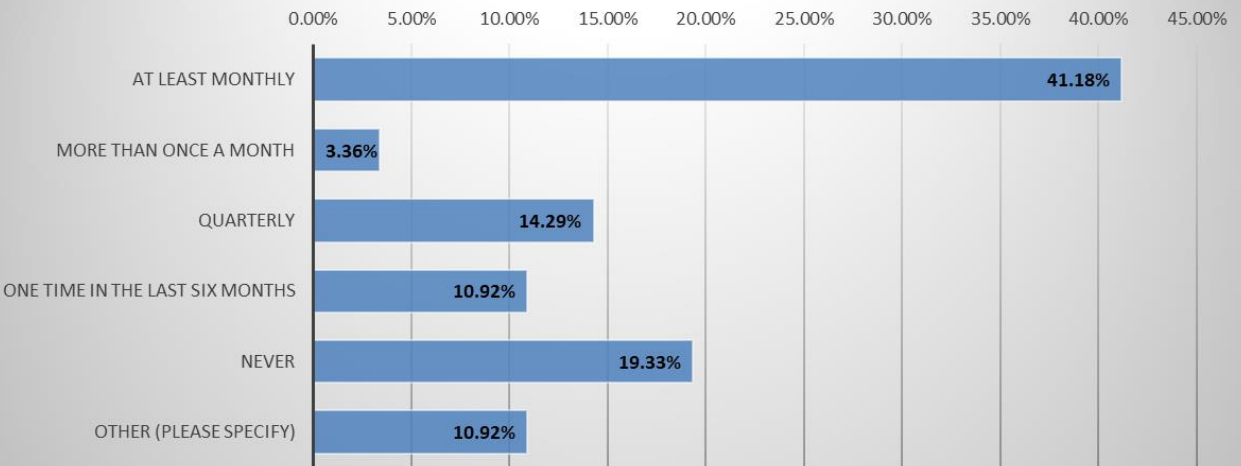
Medications Prescribed Previously



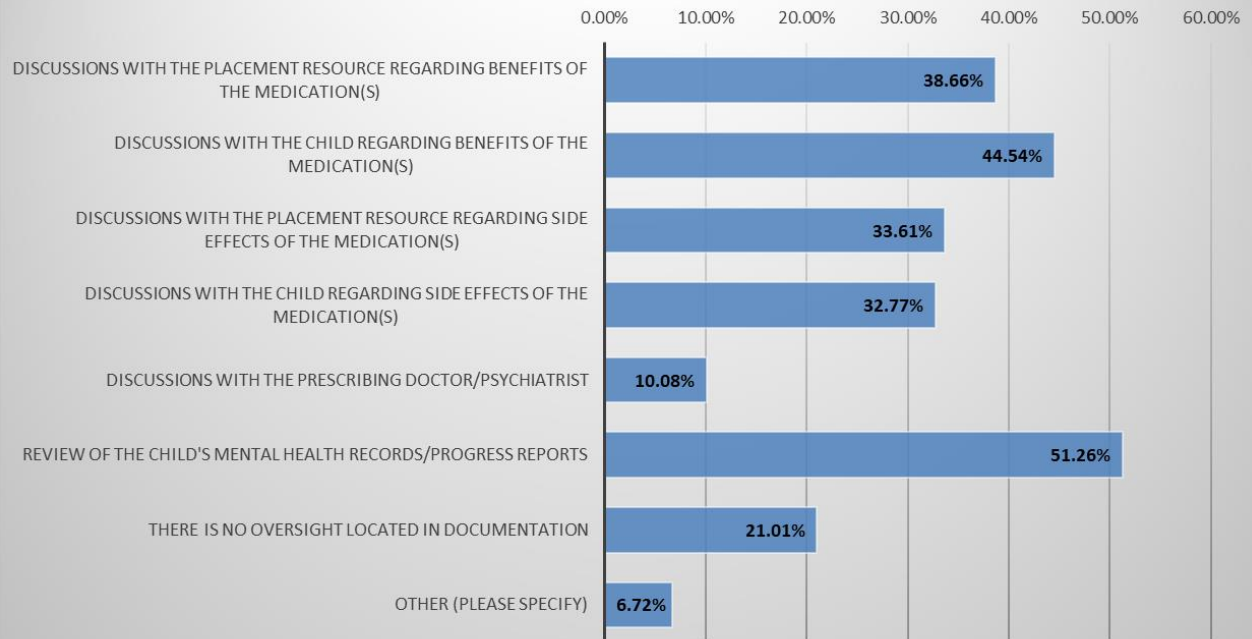
Medications Previously Prescribed



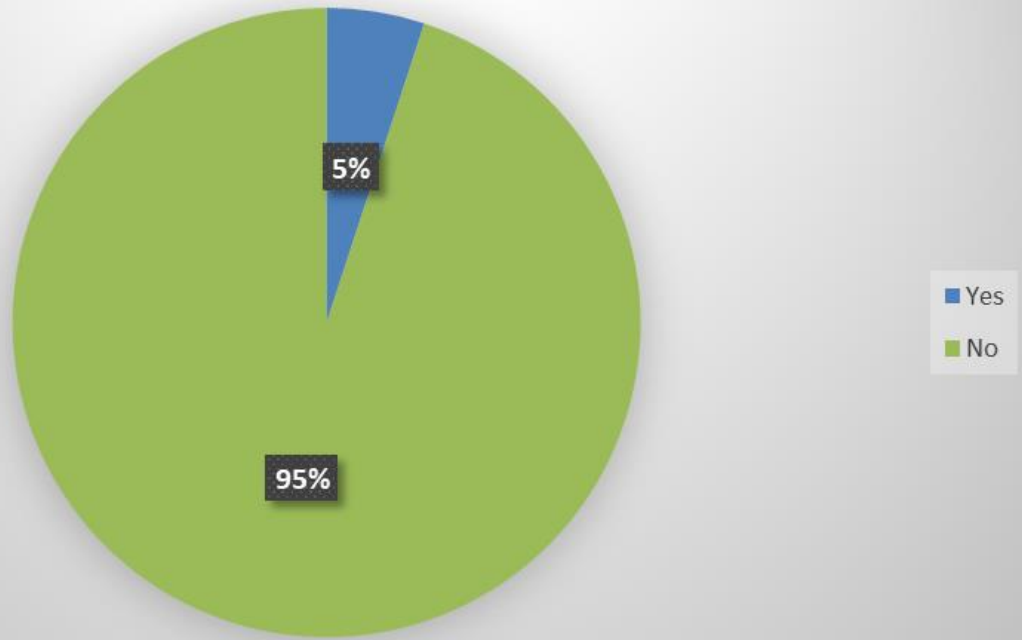
Frequency of Medication Oversight by Worker



Psychotropic Medication Oversight Information Located in File



Multiple Doctors Prescribing



Consent Form Located (Group and Residential Facilities)

