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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.

In Calendar Year 2020, CPS entered into a contract with Visionary Mental Health based out of Pierre and Rapid City, SD for the development 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.
The Regional Reviews, formerly known as Safety, Permanency and Well-Being (SPWB) onsite reviews, had been utilized to track ACE assessment completion on the placement cases selected for review. The Regional Reviews emulate the Child and Family Services Reviews as it includes not only case file reviews but also includes case related interviews with key individuals and non-case related community stakeholders. The Regional Reviews are led by a team of two Program Specialists who choose the cases, schedule review dates and case reviewers, and are available for the week of the office reviews. Each of the seven Regions are reviewed every year. The number of cases reviewed each year include a minimum of 25 in-home cases and a minimum of 45 foster care cases. Typically, between 72 and 76 cases are reviewed annually. Regional Reviews coincide with the calendar year, therefore, there is not a full year of data for the 2020 review year. The data collected for the 2020 Regional Reviews will be reflected in the 2022 Annual Progress and Service Report (APSR). A recent update to the Family and Child Information System (FACIS) is the ability to pull ACE completion rates from case files within the system; Regional Reviews will no longer be utilized for tracking ACE assessment completion with this enhancement.

Child Protection Services and the University of South Dakota (USD) is 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 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 an anti-depressant, anti-psychotic, or Attention Deficit Hyperactivity Disorder (ADHD) category 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 placement, 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 FY 2016 to FY 2017 the rate of children being prescribed psychotropic medications dropped by 1.17%. Since FY 2017 the rate has increased and is 17.75% in FY 2021, while the rate of children on Medicaid overall decreased in the past year, from 6.28% to 5.86%.
- The top seven medications prescribed to children in CPS custody for the last six years are:
  o Aripiprazole: Prescribed to treat schizophrenia, bipolar disorder, depression, and Tourette syndrome and can also treat irritability associated with autism.
Fluoxetine HCL: Prescribed to treat chemicals in the brain that may become unbalanced and cause depression, panic, anxiety, and obsessive-compulsive symptoms.

Guanfacine HCL ER: Prescribed to treat ADHD in children who are at least 6 years old.

Mirtazapine: Prescribed to treat depression.

Sertraline HCL: Prescribed to treat depression, obsessive-compulsive disorder, post-traumatic stress disorder, premenstrual dysphoric disorder, social anxiety disorder and panic disorder.

Trazodone: Prescribed to treat depression and can be used as a sedative as well.

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.

Within the past year there has been a sharp decrease in the prescription of Trazodone, decreasing from 66 prescriptions in FY 2020 to 9 prescriptions in FY 2021. Vyvanse decreased from 46 prescriptions to 16 prescriptions; and Mirtazapine also sharply decreased from 38 prescriptions to 13 prescriptions during the same timeframe. Given this trend, there are two new medications added to the top prescribed psychotropic medications:

- Escitalopram: A selective serotonin reuptake inhibitor (SSRI) prescribed to treat depression and generalized anxiety disorder.
- Dextroamphetamine-Amphetamine ER: A stimulant prescribed to treat ADHD.

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 (89%), Group Care (70%), and Residential Treatment (69%) is higher than that of children in Basic Foster Care (6%), Trial Reunification (10%), or Family Treatment Foster Care (38%).
- There were twice as many 13-year-olds on psychotropic medications in FY 2020 as there were in FY 2019 and three times as many 17-year-olds on psychotropic medications from FY 2018 to FY 2020. However, in FY 2021 the number of 13-year-olds went down by approximately a quarter, though the 14-year-olds remained consistent as that age group increased in age by one year. The group who were age 16 in FY 2020 decreased by a quarter also, as they aged to 17 in FY 2021.

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 of CPS, representation from the Human Services Center (licensed specialty hospital and the state’s only public psychiatric hospital), and representatives from provider organizations, to review trends beginning in FY 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 meet quarterly.
South Dakota CPS’ Psychotropic Medication Workgroup also completed a fidelity review to explore the documentation contained in files and alignment with policy and practice. Ninety-one 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

In comparison of annual data to fidelity review data, it was revealed there were twice as many 13-year-olds on psychotropic medications in FY 2020 as there were in FY 2019, however data revealed in FY 2021 the number of then 14-year-olds remained consistent, and the newly aged 13-year-olds psychotropic medications were prescribed went down by a quarter.

Consent for psychotropic medication review presented with 1% of consents as present in the file for applicable cases. The information on consent is drastically different from the 2021 Healthcare Oversight Plan. The fidelity review is a more in-depth review and training was provided to Psychotropic Medication Workgroup members to enhance quality of fidelity review activities.

Medication oversight fidelity review was completed and 18% of oversight was completed quarterly, 29% monthly, 10% other, and 43% never. The other responses revealed oversight with medication changes, oversight not occurring when children enter care while on psychotropic medications, and documentation of oversight not taking place until a higher level of placement was utilized.

In the Psychotropic Medication Workgroup first quarter meeting of FY 2022 the fidelity review data will be discussed, with primary focuses on trends identified throughout the completion of the data analysis as indicated above.

When the changes in trends for medications prescribed from the annual data, it was discussed with South Dakota CPS’ Psychotropic Medication Workgroup, it was indicated by members that the side effects and development of more effective medications are likely the reasons for the changes.

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 is collaborating with these providers and all have achieved accreditation or require only the onsite visits to achieve accreditation.

CPS is working through the implementation of the assessment requirement and impact on payments the FFPSA has outlined. Work has begun with the Court Improvement Project to discuss the requirements for court approvals as well.

As a preparatory element for the development of the South Dakota Title IV-E Prevention Plan as required by the FFPSA, South Dakota contracted with ACTION for Child Protection to conduct an overall assessment of CPS. An element of this assessment was a Trauma System Readiness Tool (TSRT) which was disseminated to staff and completed at a preliminary rate of 82% participation. Results of the overall ACTION survey will be shared in the 2022 APSR.

Informal assessments of a child’s mental health needs begin at CPS’ first encounter with the family including observations of the child by the Family Services Specialist, and input from the placement resource, parent, teacher, and/or mental health therapist. Through informal assessments of the behavioral, developmental, and cognitive functioning of a child, a determination is made regarding further formalized assessments that may be required for the child such as a mental health assessment, psychological assessment, psychiatric assessment, or psycho-sexual assessment. The Family Services Specialist, Family Services Specialist Supervisor, parents, and placement resource reviews the completed assessment and recommendations. Any diagnosis is discussed to determine if additional assessment, needs or monitoring may exist. If any questions arise about the child’s diagnosis, the Family Services Specialist is responsible for addressing those concerns with the provider and a determination is made if a second opinion is needed. The Family Services Specialist continues with an ongoing assessment through caseworker visits, record review, and conversations with mental health professionals, parents, and the placement resource about the child’s diagnosis and behaviors.

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.

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.
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 with 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 133 children in CPS custody over 30 days between January 1, 2020 and December 31, 2020 with no well-child exam billed to Medicaid in this timeframe. CPS completed a case review of the 133 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:

<table>
<thead>
<tr>
<th>Well-Child Visit Outcome</th>
<th>Number of Child Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child visit was combined with another comprehensive medical exam billed to Medicaid (ex: emergency medical evaluation).</td>
<td>39 children</td>
</tr>
<tr>
<td>Well-child visit was overdue and completed in January, February, or March of 2020.</td>
<td>12 children</td>
</tr>
<tr>
<td>Well-child visit was completed and billed to another agency other than SD Medicaid (CPS, Indian Health Services, etc.)</td>
<td>5 children</td>
</tr>
<tr>
<td>Well-child visit was not completed as child was in custody less than 30 days.</td>
<td>21 children</td>
</tr>
<tr>
<td>Child was listed twice with a different name. Duplicate information.</td>
<td>5 children</td>
</tr>
<tr>
<td>Well-child visit was not completed.</td>
<td>49 children</td>
</tr>
<tr>
<td>Child was considered to be a runaway during the majority of the year.</td>
<td>2 children</td>
</tr>
</tbody>
</table>

During 2020 the COVID-19 pandemic impacted health care services across the world. South Dakota providers utilized telemedicine where appropriate, but most medical providers largely stayed open throughout the duration of the pandemic while incorporating safety precautions. It does not apply the pandemic prevented children from being seen for well-child checks.

The previous year 30 children experienced exams in January, February, or March of 2020; in the same timeframe for 2021 there was a decrease to 12 children. Comparing previous year data to current year data, a new outcome was added - runaway status. This status was added to have a more accurate account of why well-child exams did not occur. An example of a child who may be on runaway status is when a child returns to the tribal reservation and is resistant or evasive in returning to CPS custody; two children this year were considered to be on runaway status during the majority or entirety of the year. In the previous year’s reporting, there were a total of 65 well-child visits not completed compared to the current reporting of 49 children who had no well-child check within the year.
These numbers equate to 3.03% of the total children in custody in 2020 without a well-child visit. The Regional Managers, Supervisors, and Family Services Specialists were provided the names of children who did not have a well-child visit in 2020 to provide added awareness and accountability related to ensuring well-child visits are completed according to the Well-Child Care Recommended Schedule. The information will be 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 2022. Child cases from 2021 will be reviewed and analyzed at that time to determine if the number of children without a well-child visit increases, 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) Avera St. Mary’s 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 coordinate the investigation, prosecution, and treatment of child abuse, while helping children heal. 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 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 in Sioux Falls is called Foster Care Clinic. Exams are completed at Child's Voice in Sioux Falls, SD, which is part of Sanford Children's Clinic. Children in CPS custody have comprehensive medical exams completed by the medical team that specializes in children who have been abused and/or neglected. The children have medical exams with reviews of medical history and development assessments 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

Psychotropic Medications Prescribed

Comparison Chart: Children in Placement and Children on Psychotropic Medications
Children on Psychotropic Medication by Age

Children 13-17 on Psychotropic Medication
Attachment 2 - Psychotropic Medication Workgroup Graphs

**Psychotropic Medication Review Placement Settings**

- **Trial Reunification**: 11
- **Specialized Foster Care**: 5
- **Psychiatric Treatment**: 8
- **Group Care**: 22
- **Kinship Care**: 13
- **Basic Foster Care**: 17
- **Intensive Residential Treatment**: 3
- **Residential Treatment**: 17

**Ages in Years**

- Age 4: 1
- Age 5: 1
- Age 6: 1
- Age 7: 6
- Age 8: 5
- Age 9: 4
- Age 10: 4
- Age 11: 6
- Age 12: 3
- Age 13: 10
- Age 14: 14
- Age 15: 8
- Age 16: 13
- Age 17: 11
- Age 18: 2
Assessment in File to Support Medication

- No: 47, 52%
- Yes: 44, 48%
Mental Health Needs Assessment
Psychological Evaluation
Psychiatric Evaluation
Other

Type of Assessment

Information in File to Support Diagnosis

No 50, 56%
Yes 39, 44%
Information Needed to Support Diagnosis

- N/A: 14
- Wrong Diagnosis Identified: 1
- Not Documented in File: 6
- No Recent Evaluations: 1
- No Psychological: 11
- No Medical Records: 5
- No Diagnosis: 6
- No Descriptions/Identification of Behaviors: 2
- Other: 22

Need for Medication Documented in File

- Yes: 41, 47%
- No: 47, 53%
Information Needed to Support Diagnosis

- N/A: 13
- No Descriptions/Identification of Behaviors: 12
- No Medical Records: 2
- No Pharmacy Claims: 1
- No Psychological: 11
- No Recent Evaluations: 2
- Not Documented in File: 3
- Not Documented in Narratives: 6
- Other: 18

Medications Previously Prescribed

- Vyvanse: 2
- Vistaril: 1
- Trazodone: 2
- Quetiapine Fumarate: 1
- Olanzapine: 2
- Mirtazapine: 3
- Methylphenidate: 1
- Klonpin: 1
- Hydroxyzine HCL: 2
- Fluoxetine HCL: 2
- Fluoxetine: 4
- Escitalopram: 1
- Duloxetine HCL (Cymbalta): 1
- Diphenhydramine HCL: 1
- Aripiprazole: 1
- Adderall: 1
Previously Prescribed Medications

![Pie chart showing percentages of previously prescribed medications]

Medications Previously Prescribed

- Vyvanse
- Vistaril
- Trazodone
- Quetiapine Fumarate
- Olanzapine
- Mirtazapine
- Methylphenidate
- Klonopin
- Hydroxyzine HCL
- Fluoxetine HCL
- Fluoxetine
- Escitalopram
- Duloxetine HCL (Cymbalta)
- Diphenhydramine HCL
- Aripiprazole
- Adderall

- Number of prescriptions for each medication
### Medication Oversight

- **Monthly**: 26 (29%) respondents.
- **Never**: 38 (43%) respondents.
- **Quarterly**: 16 (18%) respondents.
- **Other**: 9 (10%) respondents.

### Medication Consent in File

- **No**: 1 (1%) respondents.
- **Yes**: 87 (99%) respondents.