HEALTH CARE OVERSIGHT PLAN

2025-2029

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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.

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.

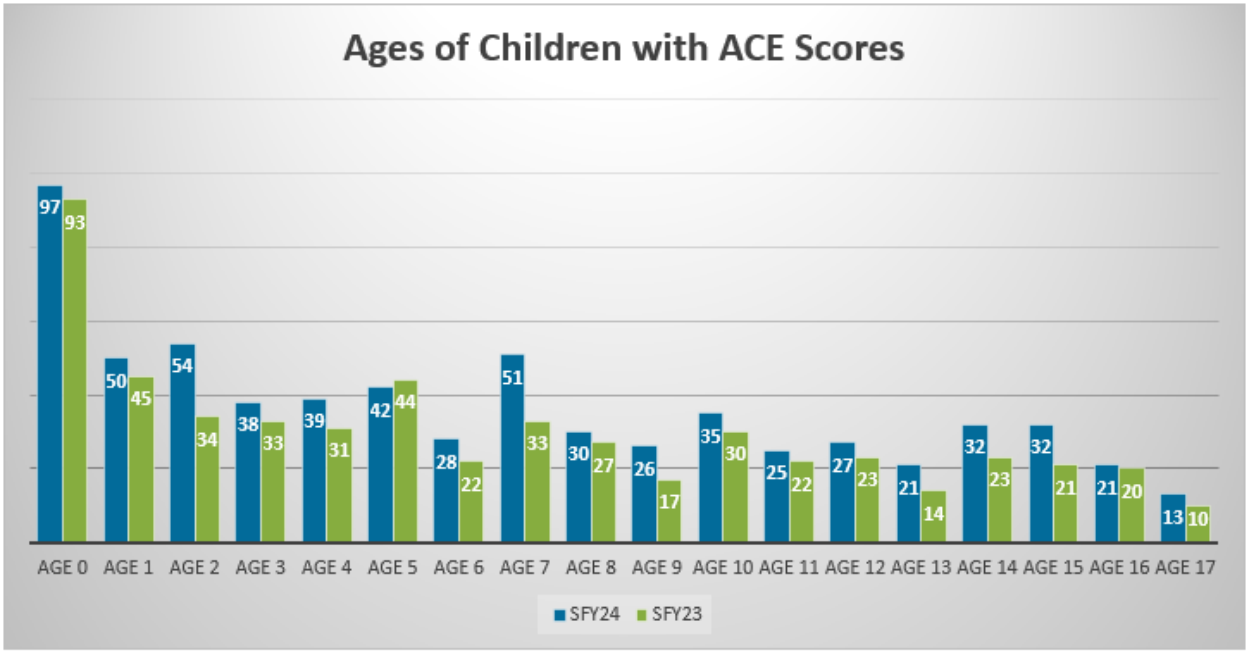
- A relationship which is characterized by respect, dignity, compassion, listening and being present in the moment and validation.
- A relationship which is based on a partnership with families, supports families and promotes empowerment.
- A recognition and appreciation of the high prevalence of traumatic 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.

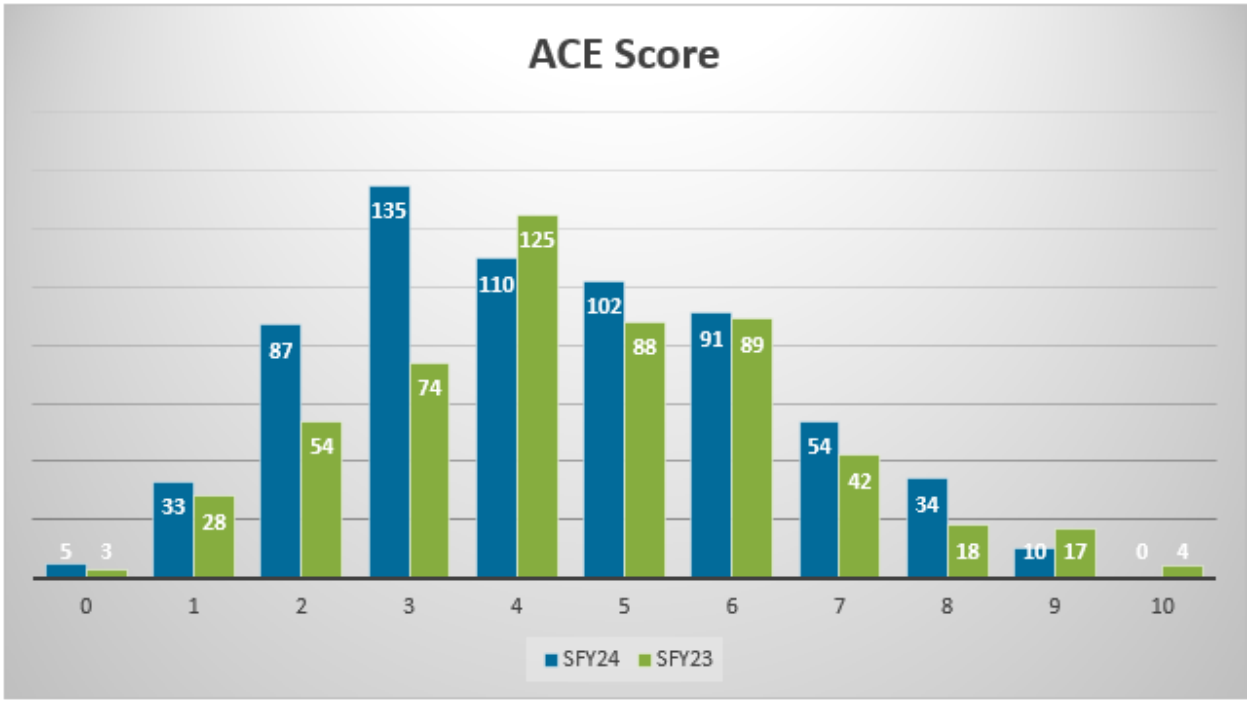
The intent of being trauma-informed is to promote a system that recognizes, understands, and appropriately responds to trauma and its' side effects on children and their families. To achieve the goals of safety, permanency and well-being within CPS, all activities by the Family Services Specialist are 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.

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 2024-2025 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 completed the tool and had discussion 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.

The FACIS system captures ACE assessments and data. There were 661 distinct ACE assessments completed from July 1, 2023-May 31, 2024. 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.





Child Protection Services and the University of South Dakota (USD) partners together on an Adverse Child Experiences (ACE) study to recognize ACEs as part of a family's environment to better understand behavior and provide appropriate supports. The data collected identifies populations and regions experiencing child adversity and therefore at risk for poor health and well-being. This information is used to identify existing supports and areas of need to promote resiliency in these communities. It is also used to inform policy that supports protective factors (safe school environment,

positive adult and peer relationships, and high cognitive skills). Specifically, this data supports 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. With early intervention and prevention efforts, the impacts of ACEs can be mitigated. This data was provided to consultant ICF for incorporation into the implementation planning of the Family First Prevention Services Act Prevention Plan and also with the Community Based Child Abuse Prevention Board, which is primarily comprised of parenting education coordinators throughout the state. The continuation of the ACE Study is captured in the 2025-2030 Child and Family Services Plan.

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 65% of the 38 applicable cases were rated as a Strength at the conclusion of the 2016 Child and Family Service Review (CFSR). Throughout Round 3 performance has gradually increased. South Dakota graduated off their program improvement plan in 2022; at that time Mental and Behavioral Health (item 18) was at an 85% strength performance.

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 the consent and oversight process were being completed according to policy and practice standards. The psychotropic medication informed consent process policy outlines the need for an explanation from the child's clinician including proposed treatment, expected outcomes, side effects and risks. The Family Service Specialist must complete a monthly review of the prescribed psychotropic medications and the effects on the child during their monthly visits. The Family Services Specialist must also document any medical appointments with the prescribing physician, ongoing labs, side effects and all non-pharmacological treatment services.

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 SFY23 to SFY24, the rate of all children on Medicaid prescribed psychotropic medications raised from 6.19% to 7.15%. The rate of psychotropic medication prescription for youth in CPS custody decreased in the past year, from SFY23 at 16.96% to SFY24 16.08%.
- Since SFY20 all children on Medicaid prescribed psychotropic medications has increased each year, whereas children in CPS custody prescribed psychotropic medications have overall decreased by 1.67%.
- 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;

    - Fluoxetine HCL: Prescribed to treat chemicals in the brain that may become unbalanced and cause depression, panic, anxiety, and obsessive-compulsive symptoms.
    - 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).
- One additional medication was added to the list as top prescribed, however, were not reported as top prescribed in years past; these medications are:
    - Lisdexamfetamine: Prescribed to treat ADHD in children who are at least 6 years old.
- The rate of prescription for each of these medications has remained 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 antianxiety 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 Group Care (59%), and Residential Treatment (84%) is higher than that of children in Basic Foster Care (23%), Trial Reunification (16%), or Family Treatment Foster Care (31%).

The percentage of children prescribed psychotropic medication within the placement setting of Group Care minimally increased in the past year, from 58% to 59%.

- There was a decrease in SFY24 from FFY23 in rate of prescription of psychotropic medications for children aged 3-6 years, from 18 to 13.

- There has also been an increase in the rate prescription of psychotropic medications to children in CPS custody aged 13-17 from 153 last year to 167 this year.
- The rate of prescription for children aged 7-12 did decrease this year compared to last from 109 to 101.

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 is currently meeting on an as needed basis and working to identify new team members moving forward due to recent turnover.

In SFY24 South Dakota utilized a member of the Continuous Quality Improvement (CQI) team to complete a fidelity review that explored documentation contained in files and their alignment with policy and practice. One hundred seventy cases were reviewed by the member of the CQI team.

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, 54% of the cases there was a consent form completed. This is an increase from the SFY2023 review where there were 53% of children in group or residential had a consent form completed. There was a 100% decrease in youth having more than one provider prescribing their psychotropic medications since the FY2023 review.

South Dakota CPS requires, at a minimum, monthly oversight for children in foster care who are on a prescribed psychotropic medication. There was a 90% decrease in cases reviewed with no documentation of psychotropic medication oversight since the FY2023 review. Oversight included 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	SFY2024

At least Monthly	37%	41%	40%
Quarterly	6%	14%	46%
Every Other Month	3%	N/A	N/A
One time in the last six months	14%	11%	12%
Never	40%	19%	2%
Other*	N/A	11%	N/A
More than Once a Month*	N/A	3%	N/A

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

Psychotropic Medication Oversight	SFY2022	SFY2023	SFY2024
Discussions with the placement resource regarding benefits of the medication(s)	12%	39%	41%
Discussions with the child regarding benefits of the medication(s)	19%	45%	64%
Discussions with the placement resource regarding side effects of the medication(s)	8%	34%	15%
Discussions with the child regarding side effects of the medication(s)	18%	33%	38%
Discussions with the prescribing doctor/psychiatrist	2%	10%	3%
Review of the child's mental health records/progress reports	19%	51%	69%
There was no oversight located in documentation	23%	21%	2%
Other*	N/A	7%	3%

*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.

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, Dakota Counseling Institute (DCI) of Mitchell, SD conducted these assessments on an ongoing basis until May 31st, 2024. CPS launched a new RFP on June 4th, 2024, to obtain a new provider to complete assessments. The letter of intent to respond to the RFP was June 18th, 2024. Proposal submissions are due on July 17th, 2024, and the anticipated award decision for a new provider is August 13th, 2024. DCI utilized 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, 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. Enhancements made this year include efforts to develop a CQI process, additional FACIS components to track duration of stay and RFP is in progress to secure a new vendor to complete CANS assessments ongoing. 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. When it is determined if a provider can be secured, the CQI team will assist in the development of a process to enhance efficacy of the completion of these assessments, including all steps along the way from application to referral, resulting in a completed assessment, as well as ongoing tracking of timeframes.

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.

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 nurses are 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.

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. Oversight and authorization of requests to extend treatment stays based on progress toward treatment goals.

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.

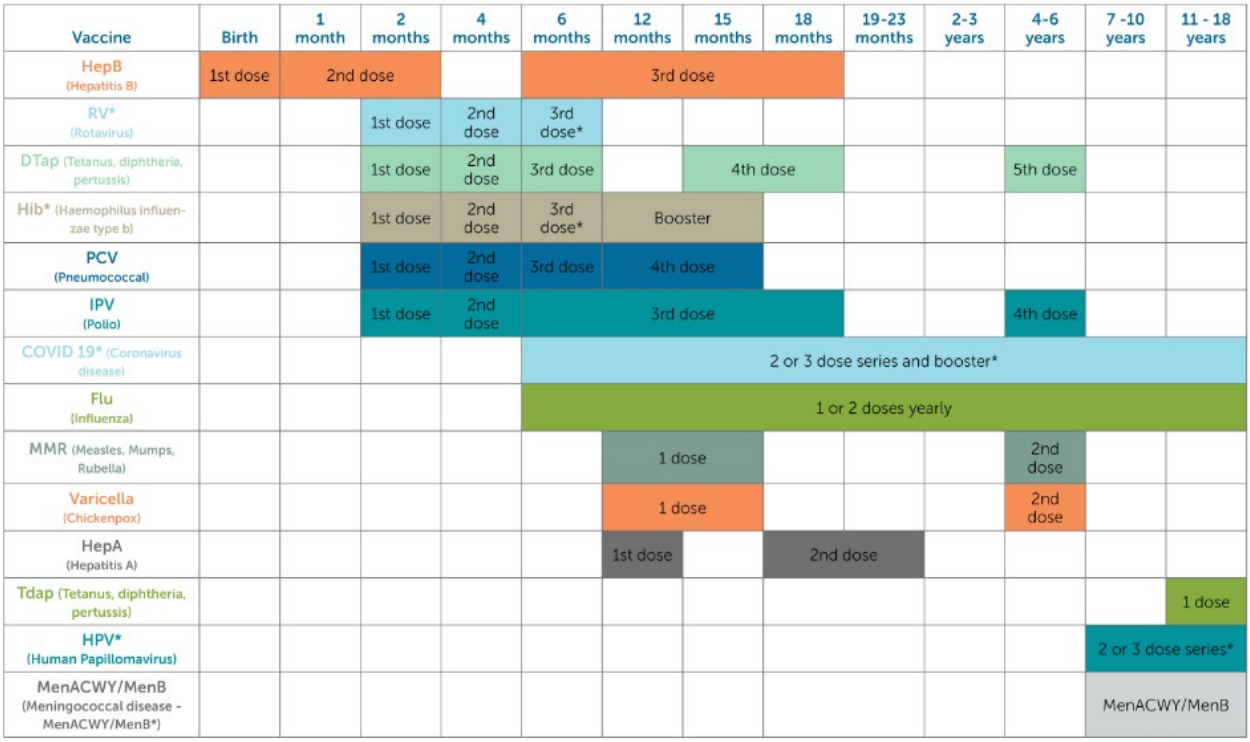
CPS requires each child to receive a health care screening within 30 days of entering care. CPS also requires a child to receive a dental exam by a dentist by their first birthday or first tooth, whichever arrives first. CPS follows the Well-Child Check-ups schedule for children in CPS placement. These 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.

Refer to Child and Family Services Plan, Agency Responsiveness to the Community and John H. Chafee Foster Care Program for further information related to the components of the transition plan development that relate to the health care needs of youth aging out of foster care.

Well Visit & Immunization ROAD MAP

Immunizations vary by age. Please check with your child's primary care provider about which immunizations are recommended for your child.

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	7-10 years	11-18 years
HepB (Hepatitis B)	1st dose	2nd dose			3rd dose								
RV* (Rotavirus)			1st dose	2nd dose	3rd dose*								
DTap (Tetanus, diphtheria, pertussis)			1st dose	2nd dose	3rd dose		4th dose				5th dose		
Hib* (Haemophilus influenzae type b)			1st dose	2nd dose	3rd dose*	Booster							
PCV (Pneumococcal)			1st dose	2nd dose	3rd dose	4th dose							
IPV (Polio)			1st dose	2nd dose	3rd dose						4th dose		
COVID 19* (Coronavirus disease)					2 or 3 dose series and booster*								
Flu (Influenza)					1 or 2 doses yearly								
MMR (Measles, Mumps, Rubella)						1 dose					2nd dose		
Varicella (Chickenpox)						1 dose					2nd dose		
HepA (Hepatitis A)						1st dose		2nd dose					
Tdap (Tetanus, diphtheria, pertussis)													1 dose
HPV* (Human Papillomavirus)												2 or 3 dose series*	
MenACWY/MenB (Meningococcal disease - MenACWY/MenB*)												MenACWY/MenB	

If your child is behind on immunizations speak with your provider about a modified schedule.

* Not all manufacturers require this dose, speak with your provider about your child's needed 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 access and keep a record of the child's immunizations, 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 130 children in CPS custody over 30 days between January 1, 2023, and December 31, 2023, with no well-child exam billed to Medicaid in this timeframe. CPS completed a review of the 130 children to determine if the child received a comprehensive medical assessment within this timeframe. As a result of the review, it was determined that 99 children received a comprehensive medical assessment. From January 1, 2023, to December 31, 2023, there were 1,670 children in care at least 30 days who required a well-child exam. Of those children, 1,639 were seen by a medical professional and met the criteria for having a well-child exam. These numbers equate to 98% of children in care for at least 30 days from January 1, 2023-December 31, 2023, had a well-child exam completed.

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 coordinate the care of Health Home patients more efficiently and effectively. 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.

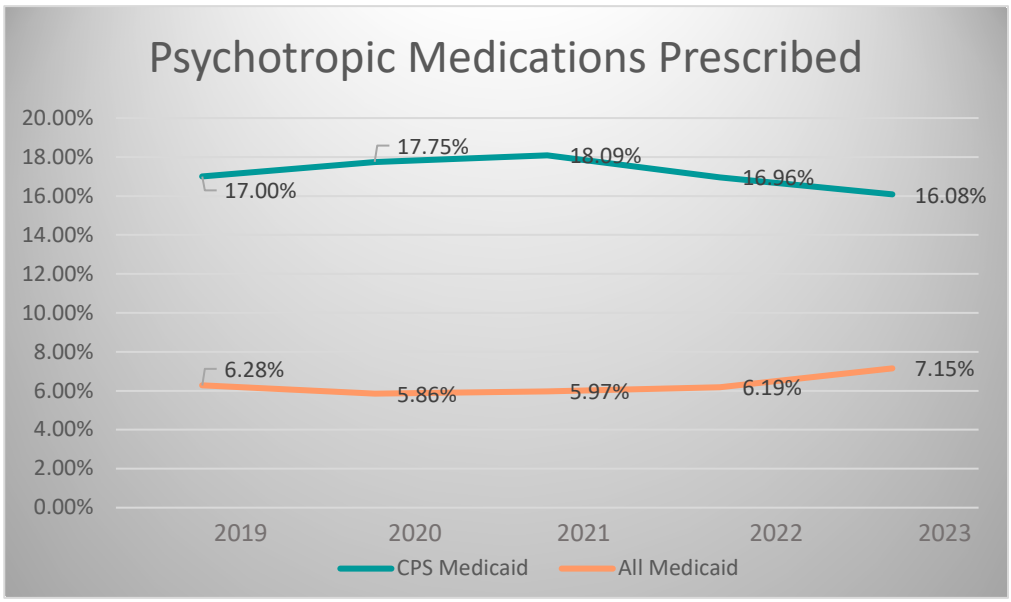
Resource parents are provided information on the availability of the Health Home program. Ultimately, the resource parent, in consultation with the Family Services Specialist, makes the determination if they will participate in the program. CPS advocates for all children in custody who have complex medical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

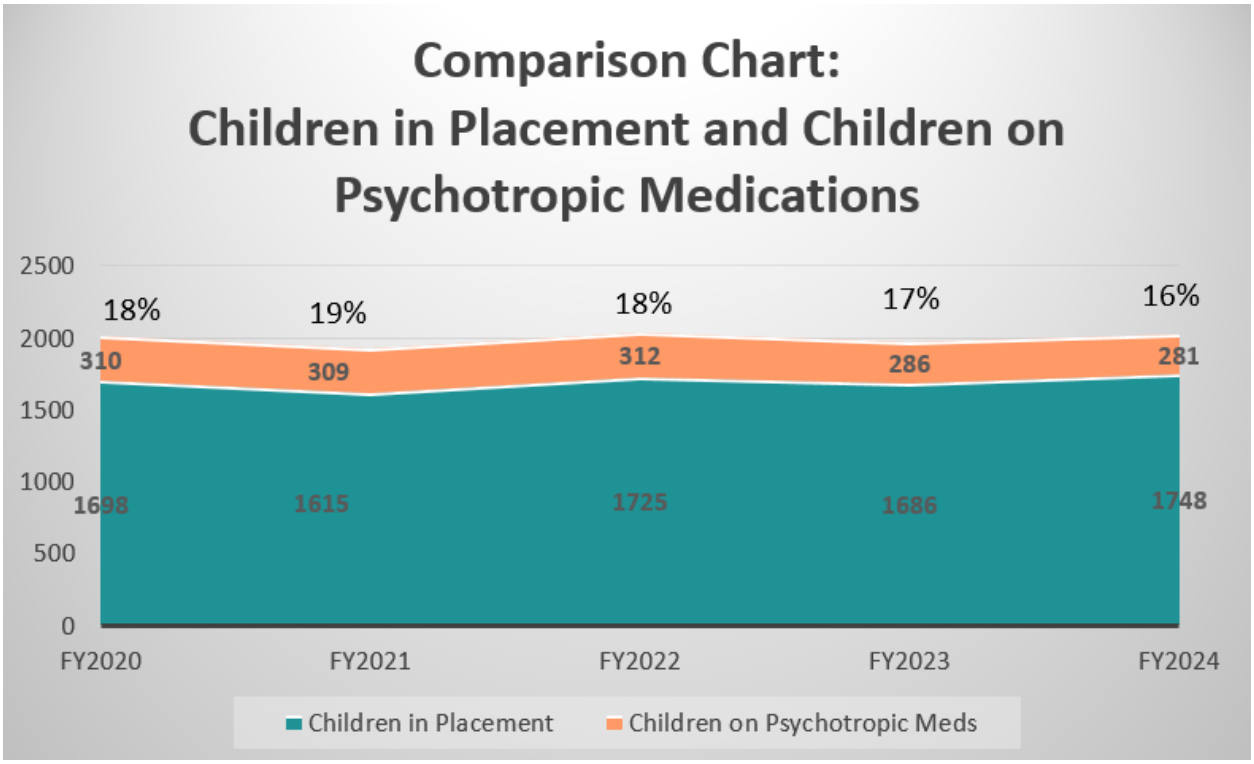
Child Advocacy Centers

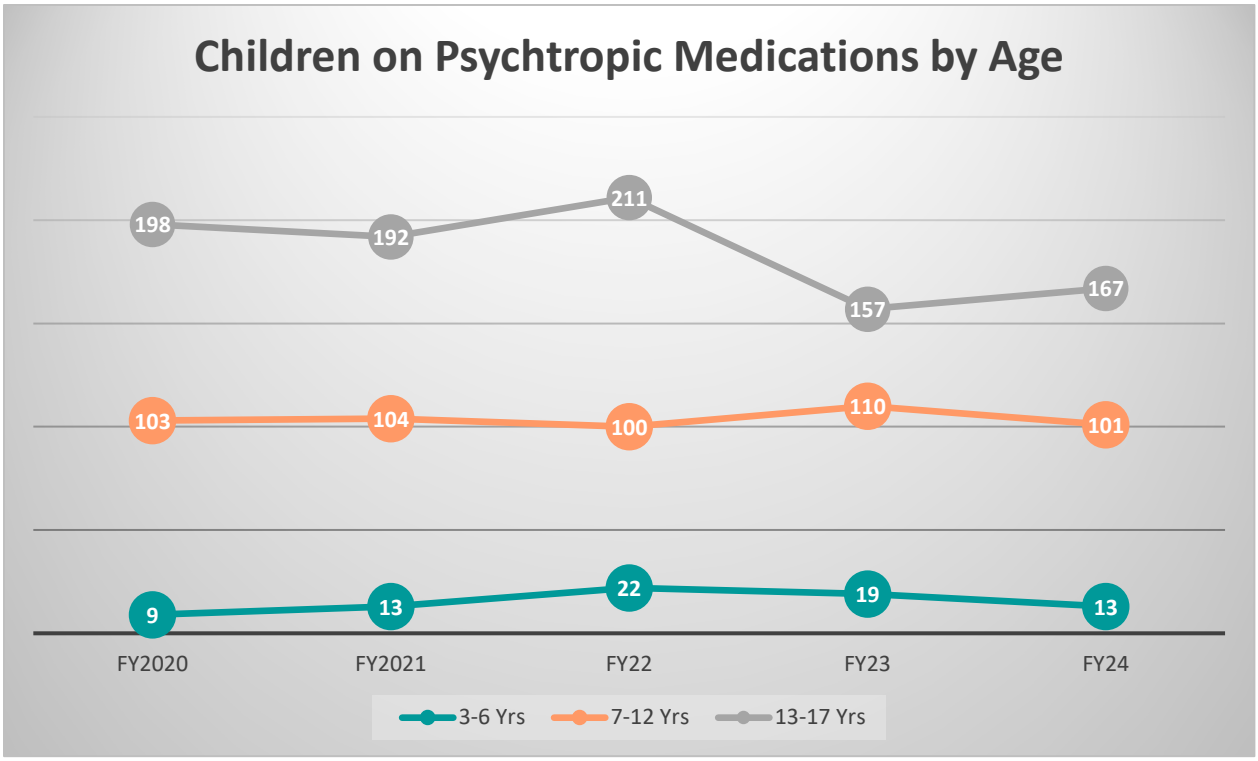
There are three accredited Child Advocacy Centers across South Dakota: 1) Children's Home Child Advocacy Center in Rapid City; 2) Child's Voice in Sioux Falls; and 3) Central South Dakota Child Assessment Center in Pierre. Oglala Lakota Children's Justice Center in Pine Ridge also serves as a child advocacy 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.

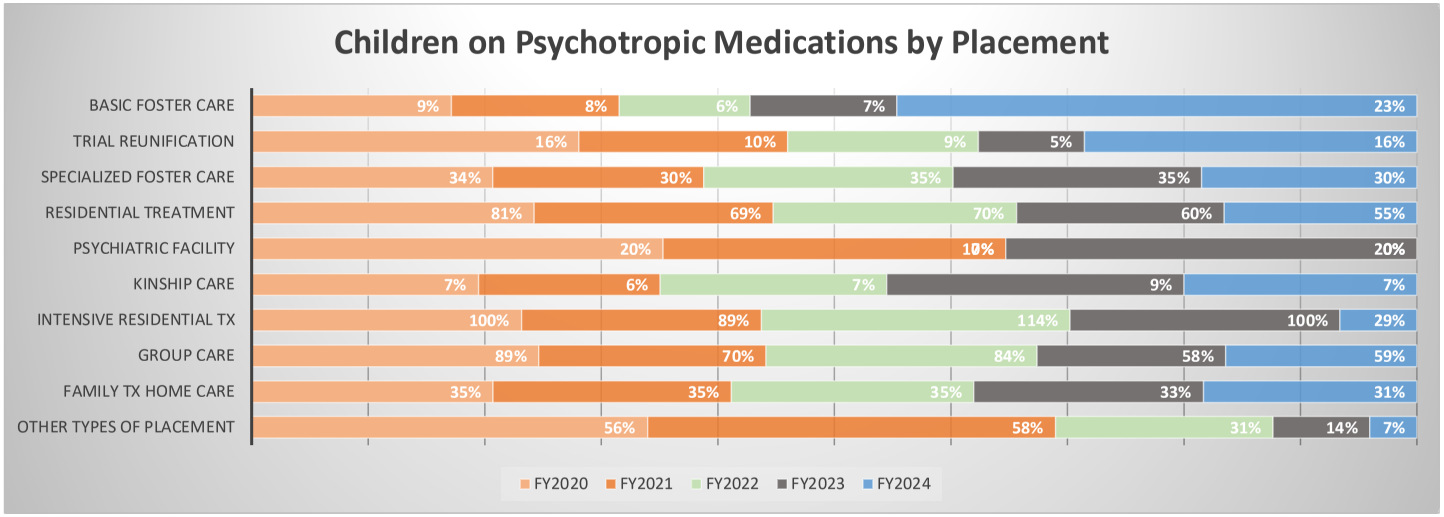
A community effort to meet the health care needs of children in foster care includes use of the Foster Care Clinic. Children in CPS custody have comprehensive medical exams completed by a medical team that specializes in child abuse and maltreatment. In Sioux Falls, exams are completed in partnership 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.

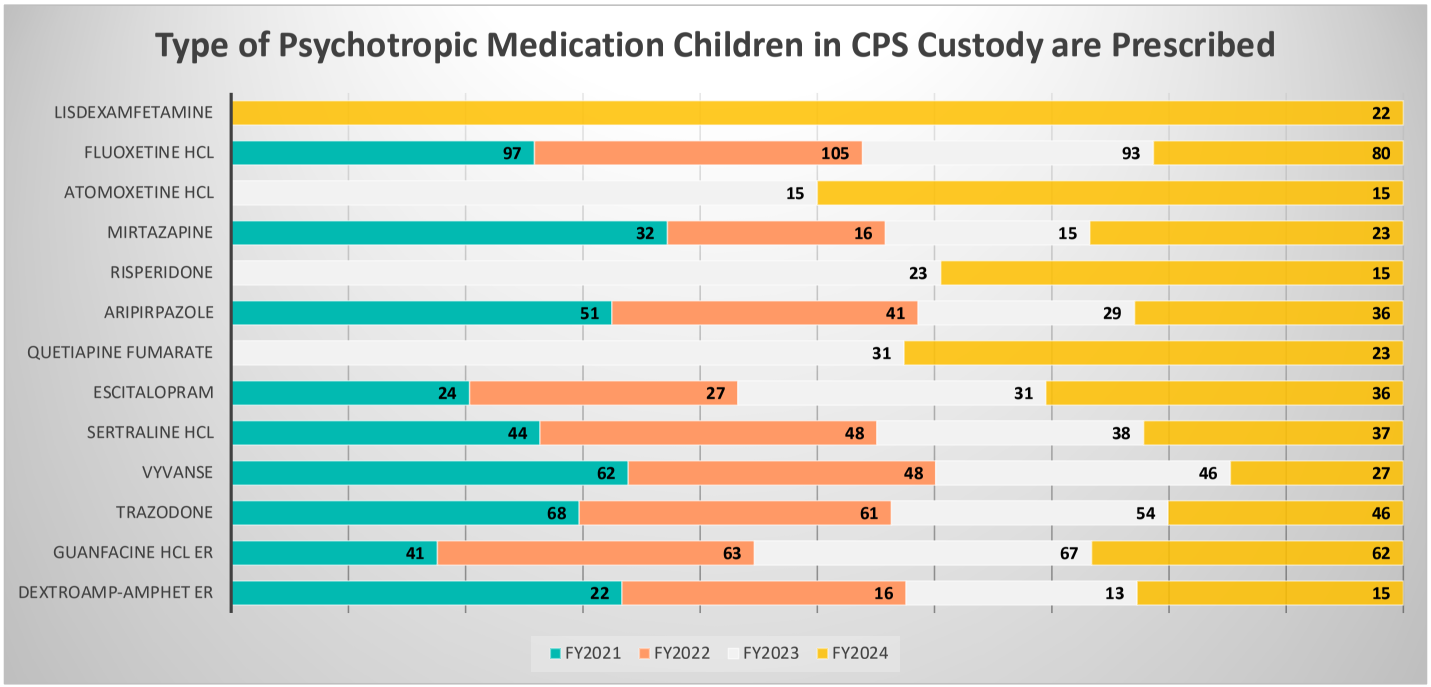
Attachment 1- Psychotropic Medication Graphs



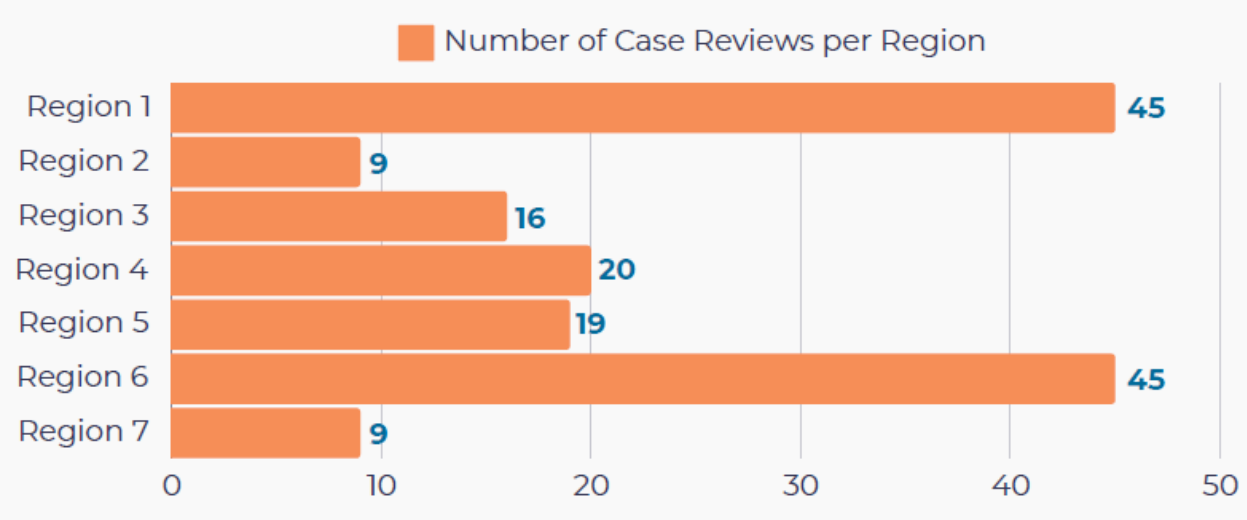


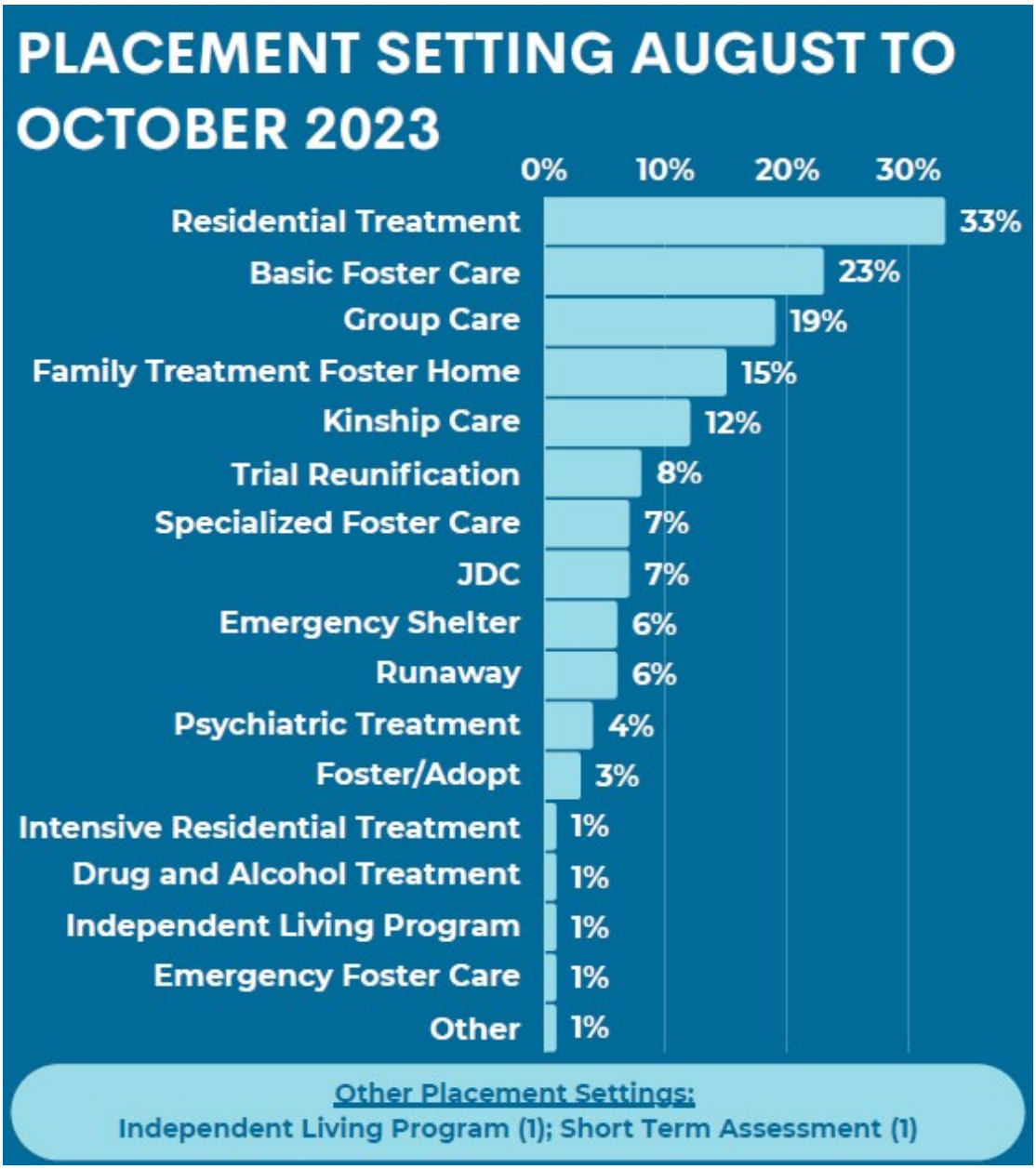

Children on Psychtropic Medications by Age
198
192
211
157
167
103
104
100
110
101
9
13
22
19
13
FY2020
FY2021
FY22
FY23
FY24
3-6 Yrs
7-12 Yrs
13-17 Yrs

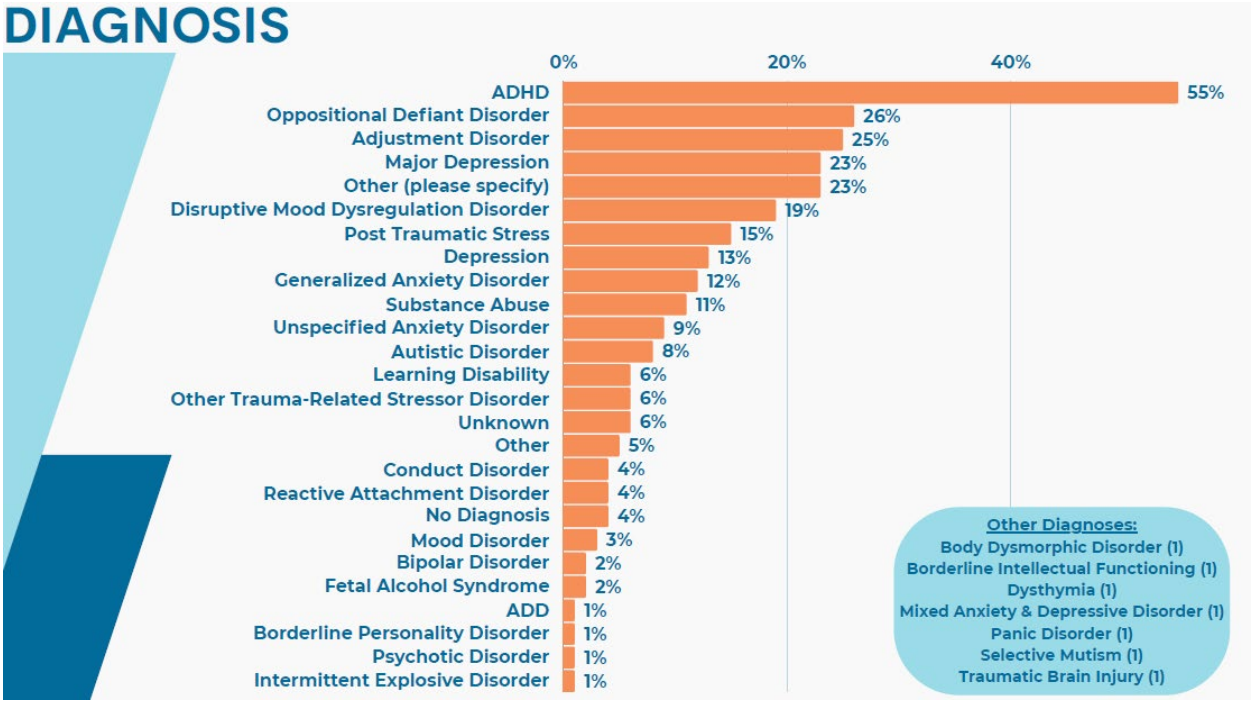

Children on Psychotropic Medications by Placement
BASIC FOSTER CARE
9%
8%
6%
7%
23%
TRIAL REUNIFICATION
16%
10%
9%
5%
16%
SPECIALIZED FOSTER CARE
34%
30%
35%
35%
30%
RESIDENTIAL TREATMENT
81%
69%
70%
60%
55%
PSYCHIATRIC FACILITY
20%
10%
20%
KINSHIP CARE
7%
6%
7%
9%
7%
INTENSIVE RESIDENTIAL TX
100%
89%
114%
100%
29%
GROUP CARE
89%
70%
84%
58%
59%
FAMILY TX HOME CARE
35%
35%
35%
33%
31%
OTHER TYPES OF PLACEMENT
56%
58%
31%
14%
7%
FY2020
FY2021
FY2022
FY2023
FY2024


Type of Psychotropic Medication Children in CPS Custody are Prescribed
LISDEXAMFETAMINE
22
FLUOXETINE HCL
97
105
93
80
ATOMOXETINE HCL
15
15
MIRTAZAPINE
32
16
15
23
RISPERIDONE
23
15
ARIPIRPAZOLE
51
41
29
36
QUETIAPINE FUMARATE
31
23
ESCITALOPRAM
24
27
31
36
SERTRALINE HCL
44
48
38
37
VYVANSE
62
48
46
27
TRAZODONE
68
61
54
46
GUANFACINE HCL ER
41
63
67
62
DEXTROAMP-AMPHET ER
22
16
13
15
FY2021
FY2022
FY2023
FY2024

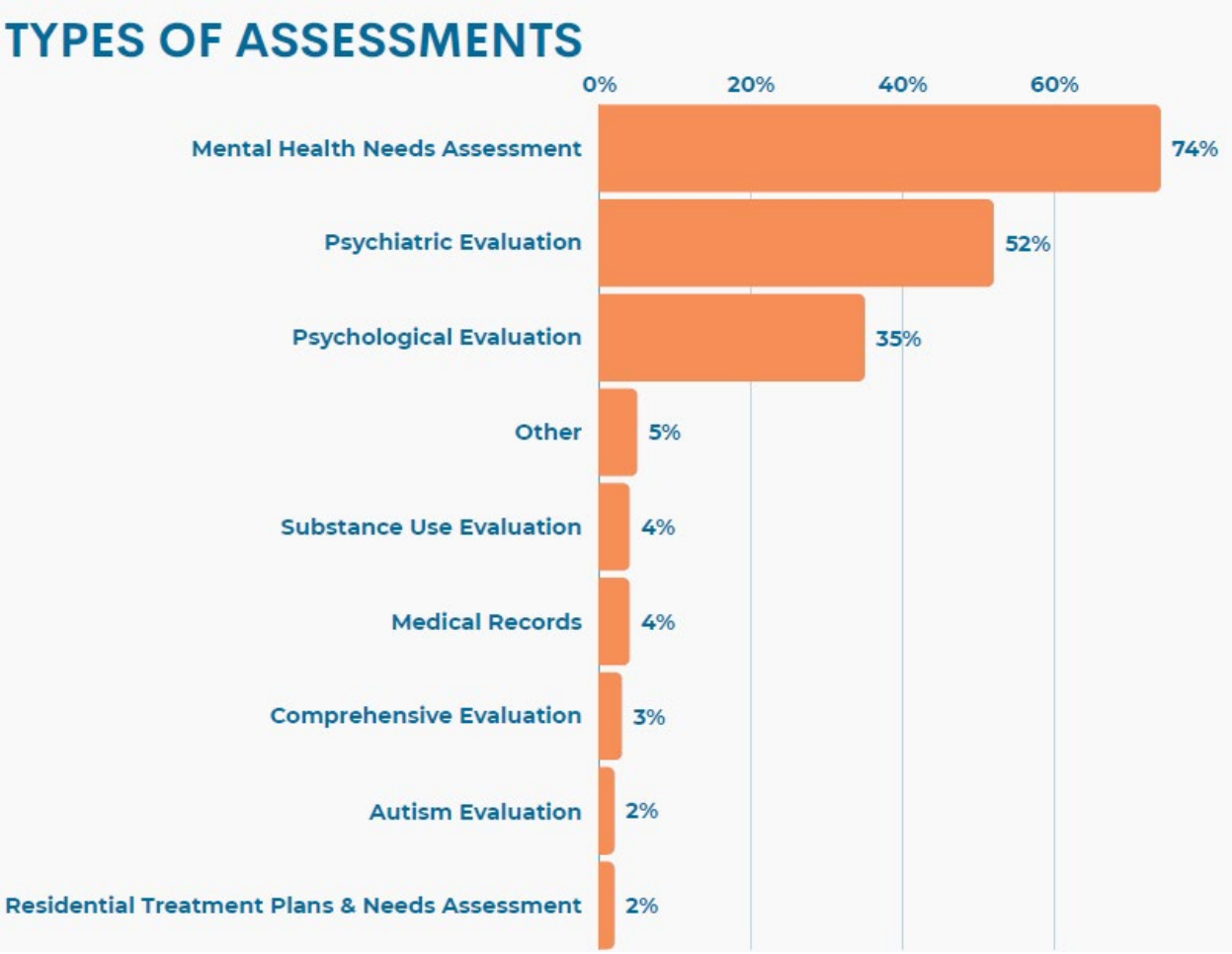
Attachment 2 - Psychotropic Medication Workgroup Graphs

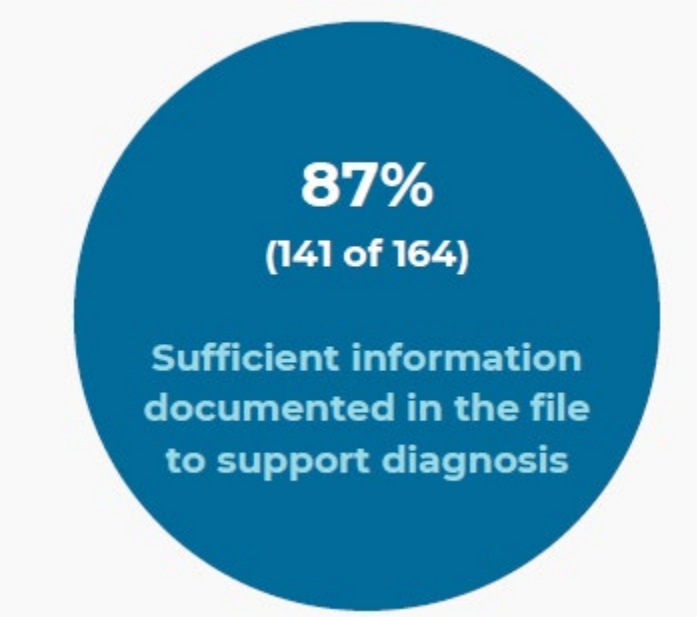


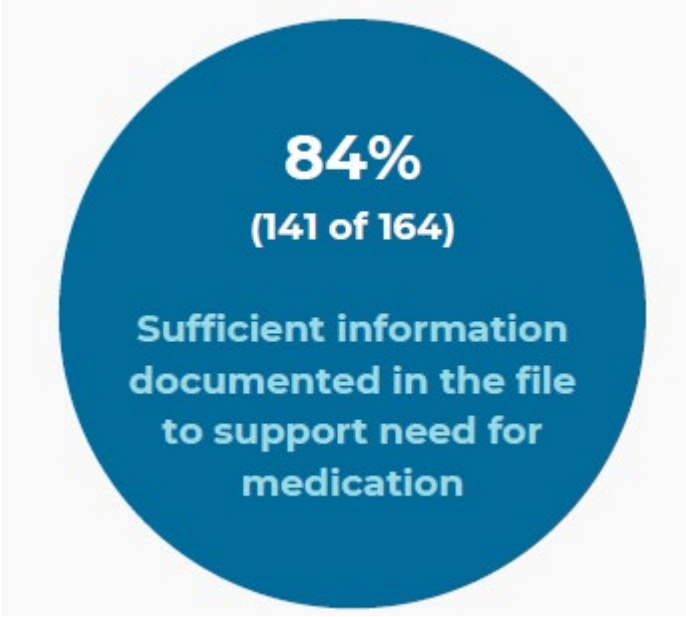

PLACEMENT SETTING AUGUST TO OCTOBER 2023
0%
10%
20%
30%
Residential Treatment 33%
Basic Foster Care 23%
Group Care 19%
Family Treatment Foster Home 15%
Kinship Care 12%
Trial Reunification 8%
Specialized Foster Care 7%
JDC 7%
Emergency Shelter 6%
Runaway 6%
Psychiatric Treatment 4%
Foster/Adopt 3%
Intensive Residential Treatment 1%
Drug and Alcohol Treatment 1%
Independent Living Program 1%
Emergency Foster Care 1%
Other 1%
Other Placement Settings:
Independent Living Program (1); Short Term Assessment (1)

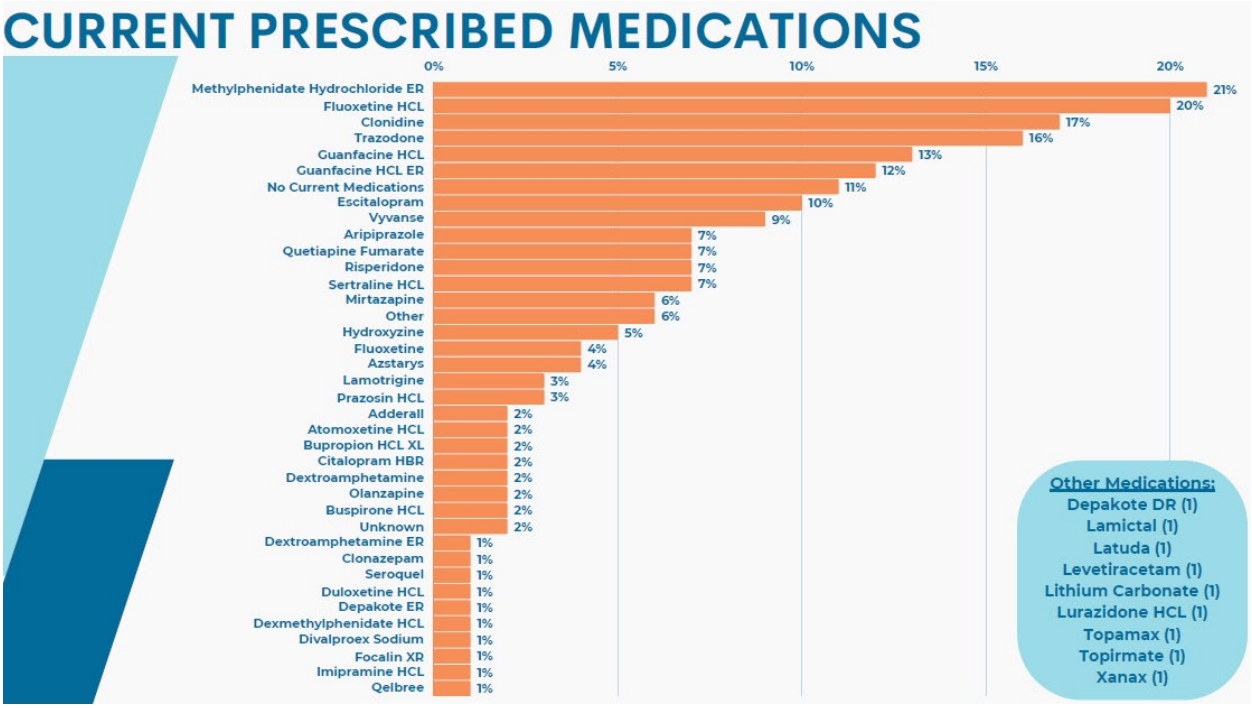

DIAGNOSIS
0%
20%
40%
ADHD 55%
Oppositional Defiant Disorder 26%
Adjustment Disorder 25%
Major Depression 23%
Other (please specify) 23%
Disruptive Mood Dysregulation Disorder 19%
Post Traumatic Stress 15%
Depression 13%
Generalized Anxiety Disorder 12%
Substance Abuse 11%
Unspecified Anxiety Disorder 9%
Autistic Disorder 8%
Learning Disability 6%
Other Trauma-Related Stressor Disorder 6%
Unknown 6%
Other 5%
Conduct Disorder 4%
Reactive Attachment Disorder 4%
No Diagnosis 4%
Mood Disorder 3%
Bipolar Disorder 2%
Fetal Alcohol Syndrome 2%
ADD 1%
Borderline Personality Disorder 1%
Psychotic Disorder 1%
Intermittent Explosive Disorder 1%
Other Diagnoses:
Body Dysmorphic Disorder (1)
Borderline Intellectual Functioning (1)
Dysthymia (1)
Mixed Anxiety & Depressive Disorder (1)
Panic Disorder (1)
Selective Mutism (1)
Traumatic Brain Injury (1)


79%
(128 of 163)
ASSESSMENTS IN THE FILE TO SUPPORT DIAGNOSIS & NEED FOR MEDICATION

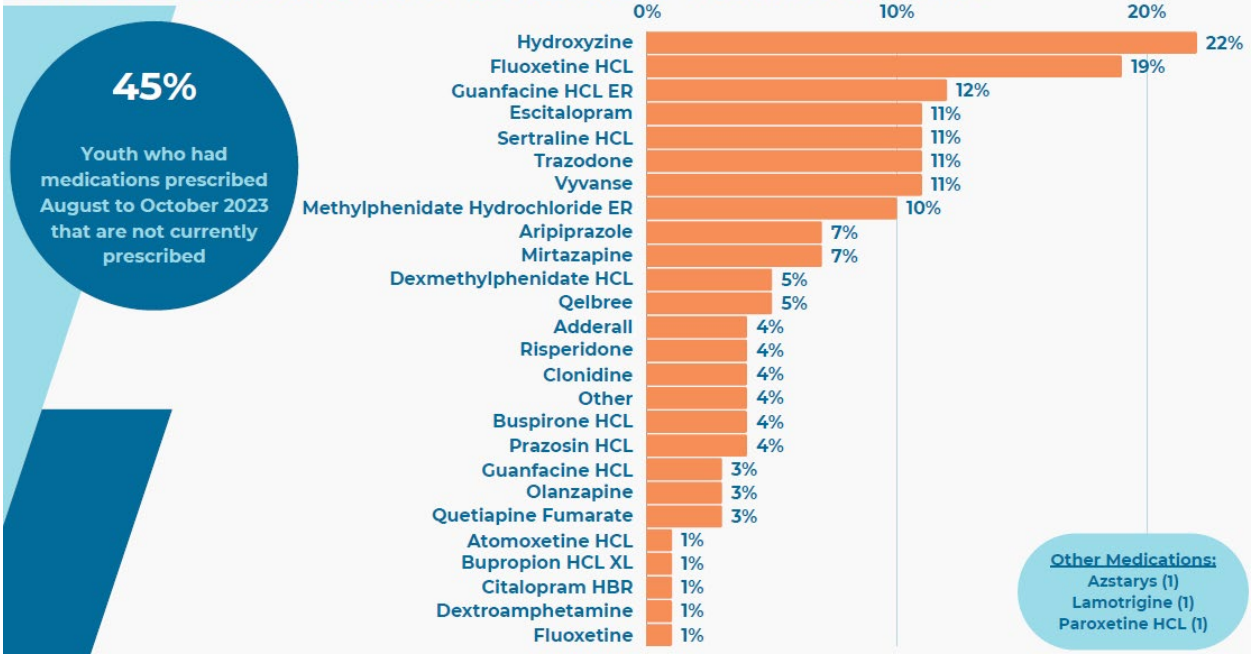

TYPES OF ASSESSMENTS
0%
20%
40%
60%
Mental Health Needs Assessment
74%
Psychiatric Evaluation
52%
Psychological Evaluation
35%
Other
5%
Substance Use Evaluation
4%
Medical Records
4%
Comprehensive Evaluation
3%
Autism Evaluation
2%
Residential Treatment Plans & Needs Assessment
2%


87%
(141 of 164)
Sufficient information documented in the file to support diagnosis

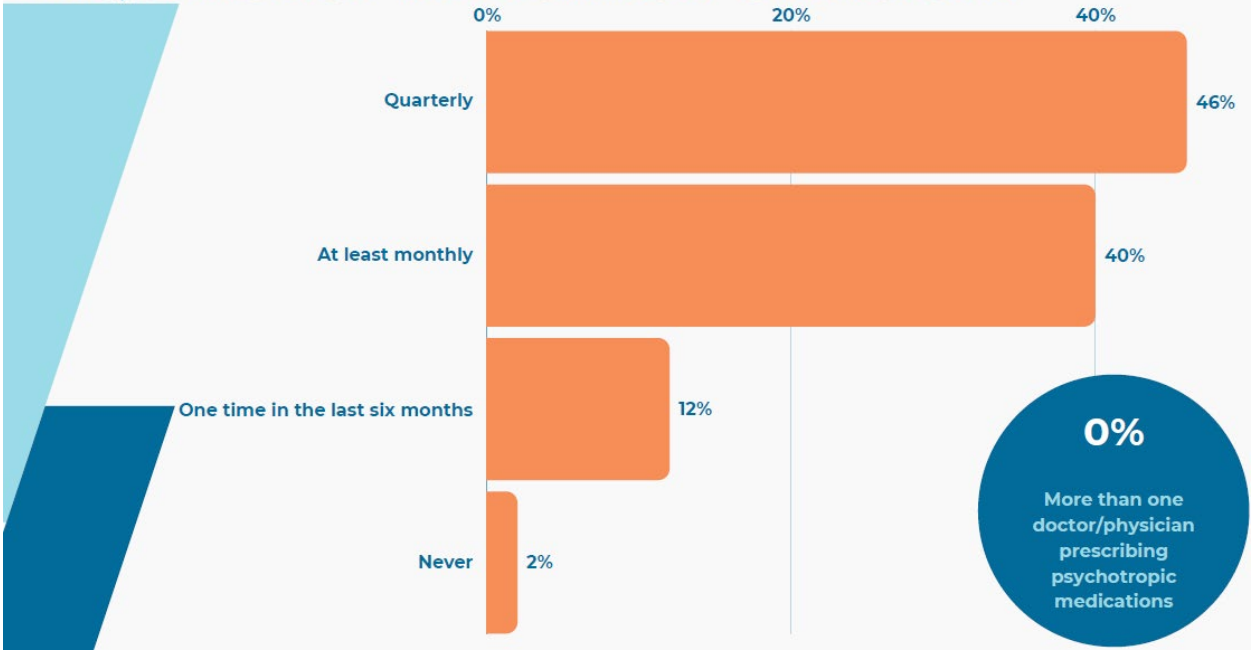

84%
(141 of 164)
Sufficient information documented in the file to support need for medication


CURRENT PRESCRIBED MEDICATIONS
0%
5%
10%
15%
20%
Methylphenidate Hydrochloride ER 21%
Fluoxetine HCL 20%
Clonidine 17%
Trazodone 16%
Guanfacine HCL 13%
Guanfacine HCL ER 12%
No Current Medications 11%
Escitalopram 10%
Vyvanse 9%
Aripiprazole 7%
Quetiapine Fumarate 7%
Risperidone 7%
Sertraline HCL 7%
Mirtazapine 6%
Other 6%
Hydroxyzine 5%
Fluoxetine 4%
Azstarys 4%
Lamotrigine 3%
Prazosin HCL 3%
Adderall 2%
Atomoxetine HCL 2%
Bupropion HCL XL 2%
Citalopram HBR 2%
Dextroamphetamine 2%
Olanzapine 2%
Buspirone HCL 2%
Unknown 2%
Dextroamphetamine ER 1%
Clonazepam 1%
Seroquel 1%
Duloxetine HCL 1%
Depakote ER 1%
Dexmethylphenidate HCL 1%
Divalproex Sodium 1%
Focalin XR 1%
Imipramine HCL 1%
Qelbree 1%
Other Medications:
Depakote DR (1)
Lamictal (1)
Latuda (1)
Levetiracetam (1)
Lithium Carbonate (1)
Lurazidone HCL (1)
Topamax (1)
Topirmate (1)
Xanax (1)

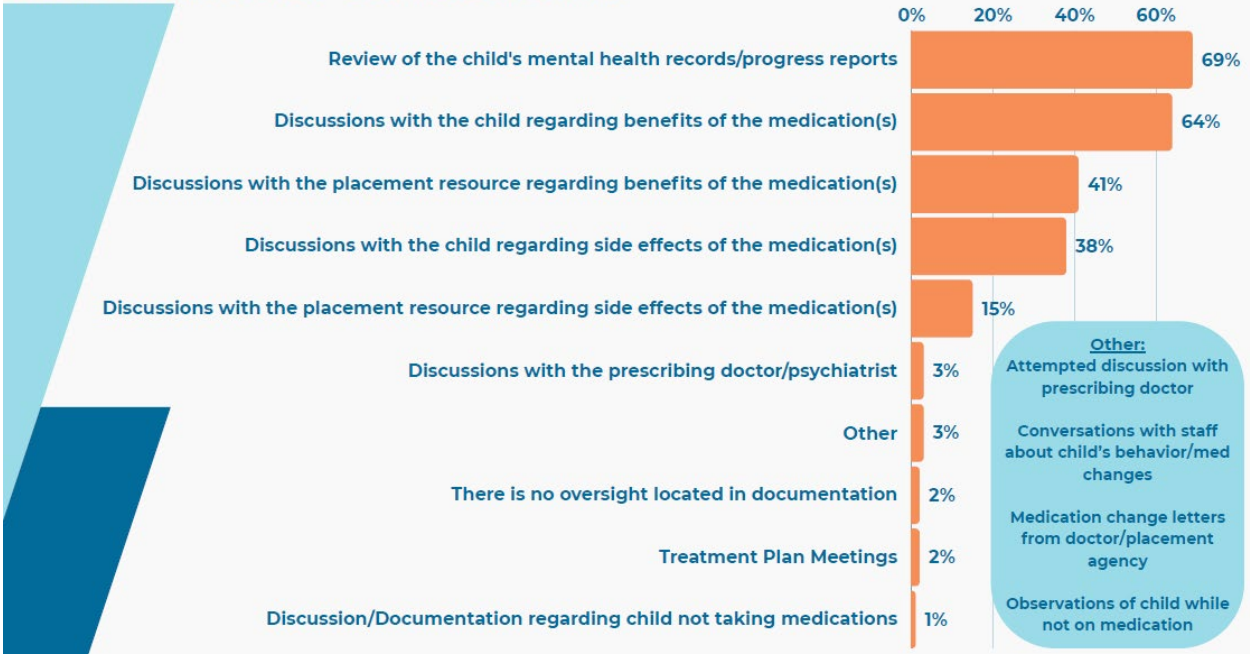
MEDICATIONS NO LONGER PRESCRIBED



FREQUENCY OF MEDICATION OVERSIGHT



MEDICATION OVERSIGHT



GROUP/RESIDENTIAL YOUTH:

USE OF CONSENT FOR MEDICATION FORM