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**South Carolina
Department of Social Services
2017 Annual Progress and Services Report
Update To The Health Care Oversight and
Coordination Plan
2015 – 2019
Child and Family Services Plan**

Health Care Oversight and Coordination Plan

In accordance with **The Child and Family Services Improvement and Innovation Act** (P.L.-112-34)- section 422 (b)(15)(A) of the Act, the SCDSS has worked diligently with other state partners and private provider agencies to advance several strategies, to support the implementation of the Health Care Oversight and Coordination Plan (HCOCP). One of the major foundational pieces of the HCOCP has been the prospective consent for psychotropic medications in Psychiatric Residential Treatment Facilities (PRTFs) statewide. The current procedures utilizing the SCDSS Clinical Team to review requests prospectively, to prescribe psychotropic medications in the PRTFs in South Carolina, are fully prospective, except in the cases of emergencies or the need for PRN medications. A *Notification Regarding Psychotropic Medication* form is completed by the treating provider for each of the following circumstances:

- o New medication initiation.
- o Medication discontinuation.
- o Titration of a medication outside the dosage range previously agreed upon.
- o Continuation of a medication started 6+ months ago.
- o Emergency medication administration.
- o Continuation of medications at time of admission to a congregate care facility.

A notification form is not necessary prior to making a medication decision for emergency medication use or continuing medications at the time of admission to a congregate care facility. This prospective review has been in place from the beginning of FFY 2014 to the current FFY 2015 (approximately 1 year and 8 months). The evaluation component of this process has been hindered by the absence of a Medical Director. The previous Medical Director left shortly after the beginning of FFY 2015, and the statewide Lead Clinical staff person who managed the prospective oversight process vacated the position midway through FFY 2015. The SCDSS hired a Medical Director who specializes in Child Psychiatry, who began employment with the SCDSS on 6/15/15. The SCDSS has hired a new Lead Clinical staff person who will begin in that position in the fourth quarter of FFY 2015. The Lead Clinical staff person will support the SCDSS in prescription oversight process for PRTFs and data analysis of usage to assess impact of oversight. *See Goal 2, Objective 2, in “3. Update to the Plan for Improvement and Progress Made to improve Outcomes”

Both the part-time child psychiatrists and the Lead Clinical staff person will resume efforts to collaborate with the congregate care residential providers, the S.C. Department of Mental Health (SCDMH) and the S.C. Department of Health and Human Services (SCDHHS), to establish the second phase of a prescription oversight process. This second phase will enable the process to be uniform and streamlined for children in foster care in the community, and be one that is transparent and engages prescribing healthcare professionals, insurers, and the SCDSS.

Also, the SCDSS, the S.C. Department of Health and Human Services (SCDHHS) and the Select Health Managed Care Organization (MCO) have held monthly phone calls throughout FFY 2016, to develop solutions for tracking children in foster care and the services that they receive. The SCDSS has requested critical, medical-encounter data for children in foster care, since the selection of a single MCO in November 2012. The purpose for gathering this data is to track: the number of children in foster care on psychotropic medications; the rate of usage of prescribed medications; the EPSDT appointments and mental health and trauma screenings are compliant with the SCDSS required timeframes; the access to physicians in and out of network; the proximity of services to where the child in foster care lives; the number of emergency room visits, etc.

The core problem has been that children in foster care had no specific identifier in the Medicaid-encounter data in South Carolina. There was no previous methodology to separate out current children in care vs. children that had been adopted and children receiving SSI. After monthly calls and multiple data exchanges with SCDSS Information Systems staff, Select Health data staff and the SCDHHS Information Systems staff, the result is children in foster

care finally received a specific identifier. This identifier means that children in care can be identified with the MCO and the services can be tracked as of March 2015. Hence, the SCDSS has been partnering with the SCDHHS, the MCO and the SC Revenue and Fiscal Affairs (RFA) Office, which is the State's data warehouse agency that provides Medicaid-encounter data, to provide outcome and trend data for prescription oversight/EPSTDT/medical assessments, etc. Preliminary data has been produced related to the EPSTDT screenings, medical assessments and behavioral health screenings, and will be reviewed by the Foster Care Advisory Committee (FCAC) in July 2015. *See Goal 2, Objective 2, in "3. Update to the Plan for Improvement and Progress Made to improve Outcomes.

Since early CY2013, the Foster Care Advisory Committee (FCAC) has advised the SCDSS in the development of the state's (HCOCP) for children in the South Carolina's Foster Care System. The purpose of the Foster Care Health Advisory Committee is to champion a system of care that assures that children in foster care have timely access to and are provided appropriate medical and mental health care in a coordinated manner. The SCDSS and Department of Health and Human Services (HHS) partner together to lead the FCAC meetings on a quarterly basis. These meetings include a wide array of medical and behavioral health professionals statewide, such as the physician community of Pediatricians (representing, in part, the SC chapter of Academy of Pediatrics) and the Select Health Managed Care Organization (MCO) and other clinics, a forensic pediatrician representing the Children's Advocacy Centers (CACs), and child psychiatrists representing the SCDSS and the SCDMH. The FCAC also included other behavioral health professionals from the Department of Mental Health (DMH), private community-based Licensed Independent Professionals (LIPs), the Palmetto Association for Children and Families, Therapeutic Foster Care, Congregate Care and Rehabilitative Behavioral Health Services (RBHS) providers. This group is divided into three (3) sub-committees or Work Groups: Access to Care, Trauma-Informed Care, and Medical Assessment. Each of these sub-committees has been charged with making recommendations to the SCDSS for the HCOCP, for the 2015-2019 CFSP.

One of the major recommendations of the FCAC was to have a standardized protocol for medical screenings, assessments, and follow-up for all children entering Foster Care needs to be in place. This protocol also needs to be mindful of, and adhere to, EPSTDT requirements which will provide a comprehensive longitudinal record for DSS to maintain and use to update the Education and Health Passport. The Protocol should include a standardized developmental screen at one month into care and follow the American Academy of Pediatrics recommendations for wellness visits. A template needs to be offered to Providers which is compatible with the Physician's Electronic Health Record.

The Medical Assessment Workgroup within the FCAC has revised the Comprehensive Initial Medical Assessment Form (DSS Form 3057) to be utilized by all physicians, SCDSS Caseworkers and caregivers statewide. This will support the capturing of up-to-date medical information, and track follow-up appointments. In the effort to move closer to a Medical Home Model, the FCAC has identified several barriers to the consistent implementation of the Initial Comprehensive Medical Assessment and continued follow-up through the Education and Health Passport:

- Medical assessment information on the paper form does not transport well and frequently does not get delivered to the caseworker who is designated to enter the medical information into the SCDSS CAPSS database system.
- Caregivers/caseworkers frequently do not have the paper copy completed by a physician or complete the caseworker portion of the document.
- There is no current mechanism for physicians to electronically deliver the medical information directly to the SCDSS to avoid loss of information or misinterpretation of the information.
- When the medical information is completed on the Initial Comprehensive Medical Assessment Form by the physician and case worker, it is not entered into just one location in the CAPSS database (multiple tabs), and the information is not populated automatically into the ongoing update document Education and Health Passport (DSS Form 30245), which can be printed and is portable, therefore ongoing tracking and follow-up is severely diminished.

In response to these issues, the FCAC along with the SCDSS has made the SCDSS' CAPSS update a priority.
*See Goal 2, Objective 2, in "3. Update to the Plan for Improvement and Progress Made to improve Outcomes."

- 2.2.1: Place the Initial Comprehensive Medical Assessment in a centralized location in CAPSS (Person Screen)
- 2.2.2: All medical data from the Initial Comprehensive Medical Assessment entered into the Person Screen will automatically populate the related fields within the Health and Education Passport
- 2.2.3: Create a portal for caregivers/foster parents/providers so they have the ability to review, update and print all information housed within the Education and Health passport
- 2.2.4: Create a portal for physicians so they can attach the Electronic Medical Record into CAPSS directly

Although the Education and Health Passport improvements were also a recommendation and goal from the Access to Care Workgroup, and are being addressed (see above), another recommendation from the 2015-2019 CFSP has been addressed during FFY 2015: a training package is being developed for physicians and other health care providers to train them on standards of care, including standardized assessment tools compatible with the Electronic Health Record (EHR) and coordination of care as they relate to children in foster care, with a separate training module for SCDSS case workers and Supervisors as brokers securing necessary services. These training modules will be developed by the University of South Carolina, Center for Child and Family Studies, and be on video, with new practitioners and Providers trained as they come online. A third training package will also be provided to the Foster Family and the child's family of origin or prospective adoptive family, focusing on understanding each child's medical needs and assisting the child in having those needs met.

Two training videos have been completed for case workers regarding general care coordination practices, around behavioral health issues and a psychopharmacology overview of some of the more prevalent medications. All SCDSS County Offices were directed by the Deputy Director for Child Welfare to bring the manual Education and Health Passports up-to-date by July 1, 2016. The Education and Health Passport will "go live" at the SCDSS on CAPSS (SACWIS) on July 11, 2106. Training videos on Psychotropic Medication Monitoring were completed during FFY 2016 and tested. During the fourth quarter of FFY 2016 and into FFY 2017, the state plans to further develop and revise the training videos in preparation for full implementation of the videos to SCDSS staff and external stakeholders. The completion of training videos for case workers and physicians is outlined in Goal 2, Objective 2, in "3. Update to the Plan for Improvement and Progress Made to Improve Outcomes.

The Access to Care Workgroup made the following recommendation: Communication between the SCDSS, the SCDHHS, the MCO and Providers, needs to be improved; this includes changes need to be made in billing or payment including a way to directly and expediently resolve disputes, both regarding approvals for services and reimbursement issues.

The SCDHHS continues to employ a SCDSS Liaison who is a direct communication link with the SCDHHS, the MCO, the SCDSS and Providers. The SCDSS has a monthly phone conference call which includes agenda items surrounding issues that have surfaced that impede access to care (i.e. inaccurate addresses, lack of service from an identified Primary Care Physician, new health plan cards going out to families, inability for provider to get paid, inaccessibility to a medical device, medication not available in MCO's formulary and suitable replacement drug, etc.). The SCDSS and the MCO e-mail the SCDSS Liaison frequently throughout the month to address issues, in between scheduled phone conferences.

Much work has been completed regarding the following recommendations from the Trauma-Informed Workgroup in the FCAC. The following recommendations have been completed:

- Development of a list of trauma-screening instruments. The trauma-focused screening protocol, including lists of trauma-screening instruments, has been finalized and was approved by the SCDSS and is awaiting the final interagency approval by the SCDMH and the Trauma-Protocol Committee.
- Collaborate with the SCDHHS to develop a specific Procedure Code and Modifier to enable Providers to bill specifically for screenings and assessments.
- Specific procedure codes for Trauma-Screening and Assessment that will allow research as to whether or not implementation of completed T-F CBT protocol results in less prescription of psychotropic medication, number of changes in placement, length of time in care, and efficacy of treatment.
- Provide training to the SCDSS Protective Services workers to enable them to do initial trauma histories/ screening.

The Program Manager for the Trauma-Informed Care initiative has recommended that one Pilot County be established during FFY 2017. The Pilot County would be the test site for the utilization of assessment and screening tools, to referral for needed Trauma-Informed Care services. Including training of the staff of the Pilot County, implementation of the Pilot Project in the County, revision of training material, evaluation, revision of the process to implement Trauma-Informed Care, and the possible decision to implement Trauma-informed Care statewide through the SCDSS, the Pilot would be approximately two (2) years.

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