Department of
HUMAN SERVICES

FFY 2020-2024
Child and Family Services Plan
Health Care Oversight and Coordination Plan

June 2020

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Health Care Oversight and Coordination Plan

State of Iowa
Iowa Department of Human Services
Division of Adult, Children and Family Services

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A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice

If a child coming into care has not had a physical health screening prior to placement, scheduling of the initial physical health screening occurs within 14 calendar days of the child coming into care. After the initial physical, children in foster care have physicals on an annual basis, or in accordance with applicable Medicaid periodicity schedule for health exams, according to the age of the child. While aware that not all social work case managers (SWCMs) ask the foster home or foster group care facility at monthly visits about the foster child's health care, the Iowa Department of Human Services (DHS) central office staff plans to obtain an Iowa Medicaid Enterprise (IME) report that separates out the children in foster care from the total number of children in the Core Set of Children's Health Care Quality Measures, which is one way to measure health outcomes for children insured under Medicaid. A SWCM's supervisor would receive the report to provide and discuss with the SWCM, as necessary.

How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home

Children have a physical upon removal with a medical professional, which identifies their health needs including emotional trauma associated with their abuse and removal from the home. SWCMs engage medical professionals in screening for the child's health needs. Considerations include but are not be limited to:

- What behaviors are we seeing?
- Do they need behavioral health intervention services (BHIS)?
- What does the needs assessment tell us?
- Why is DHS involved with this child and family?
- What issues for specific children are noted and from what source, i.e. caregiver, FSRP, DHS, FTDM participants, therapist, or the child him or herself?

All of this information helps to determine the child's treatment plan. SWCMs rely on the child's medical professionals' expertise and recommendations for treatment.

SWCMs monitor the child's health care needs identified in the child's screenings, through documentation of medical care received and the effectiveness of their treatment plan, including appropriateness and sufficiency of the therapeutic services for meeting their needs. The SWCM monitors the child's health care treatments and therapy by reviewing the foster parent's documentation and the foster group care provider's health reports sent to them, and through discussions with the child and foster care provider.

How medical information for children in care will be updated and appropriately shared, which may include developing and implementing an electronic health record

Most health care providers have electronic medical records. The foster care provider may ask for a "summary of the visit" or discharge/referral form at the end of the health care visit, if it is not automatically provided. If the health care provider does not have electronic medical records, the foster care provider can give the provider the Physical Record form and request it be completed and returned to them. The Physical Record

form includes a list of previous diseases that can be checked and dated, chronic illnesses and an area to list medications prescribed, physical examination information including vision, hearing, dental and mental health, and an area to complete preliminary diagnosis and recommendations, including any recommendations for further assessment or evaluation. The foster parent provides the Physical Record form, "summary of the visit", and other additional documentation of the child's health care to the SWCM.

Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care

The DHS continues to work on assuring that the health care records follow the child when they move to another placement outside of their medical home, or leave foster care.

The Integrated Health Home (IHH) continues if the MCOs approve it. An IHH is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience. Children with a SED and their families receive IHH services using the principles and practices of a System of Care model. The IHH serves individuals enrolled in Medicaid, which includes those receiving targeted case management (TCM) and case management through Medicaid-funded habilitation as well as those not currently receiving care coordination.

The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications

Medication monitoring at the agency level

The IME data warehouse sends a quarterly report to the Bureau Chief for Service Training and Supports for each of the five DHS Service Areas for agency level medication monitoring. The IME also sends a similar report to the Chief JCO for distribution to the other Chief JCOs for agency level medication monitoring of JCS children in foster care. The psychotropic medication report serves as a "red flag". It identifies any children who are under age 6 and prescribed psychotropic medications, and children over age 6 prescribed two or more psychotropic medications. Attachment 8B(1) outlines this information conveyed to the assigned worker's and the worker's specific case management duties. If the situation does not involve a child under age 6, or a child prescribed two or more psychotropic medications, Iowa does not have a specific indicator to identify off label uses at this time.

The previous state plan showed seven tables that provided psychotropic medication data for several fiscal years. The source for all tables was IME. The highest psychotropic medication use for foster care was in state fiscal year (SFY) 2014 of 3,354 and psychotropic medication usage decreased each year to 2,426 in SFY 2017. The

data for SFY 2018 fiscal year showed a continued decrease in psychotropic usage to 2,323.

Additionally, DHS worked with the IME regarding data and process for the monitoring of psychotropic medication for the children and youth in foster care. The IME developed a metric for measuring child psychotropic use in foster care and added it to their overall strategic plan for DHS. This will allow for data information sharing regarding percentage of children and youth in foster care prescribed psychotropic medication, related demographics, and additional red flag practices. DHS anticipates that development of a process for the IME to communicate that information to DHS will occur over SFY 2021. DHS will develop a process to utilize that data to measure the overall impact of policy changes targeted toward the use of psychotropic medication in children and youth in foster care. The IME is working on MCO performance metrics for SFY 2021 contract cycle and is considering adding performance measures to the MCO contracts that will address outcomes regarding the use of psychotropic medications in children on Medicaid. Performance measures on a systematic MCO outcome level should assist with prescriber level concerns.

Medication monitoring at the client level

Foster parent level

The DHS works with the five recruitment, retention, support and training (RRTS) providers to provide training to foster parents on medications:

- understanding what the medication is;
- what the medication is used to address;
- possible side effects of the medication;
- when to contact the child's doctor if there is a problem with the medication or the child's reaction to the medication;
- description for what a psychotropic medication is;
- when to contact the child's SWCM;
- possible alternatives to medications; and
- how the foster parent can advocate for the best interest regarding the child's health care needs.

Foster parents are part of Iowa's collaborative team in monitoring medications and the health care needs of children in foster care. The foster parent monitors for side effects and contacts the prescribing doctor if there are side effects or the medication does not address the issue for which it was prescribed. The foster parent also keeps the child's case manager informed of the medications and any issues with it. Additionally, some DHS SWCMs go with the foster parent when the child goes to their health care provider.

SWCM level

The Social Work Administrator (SWA) distributes a quarterly psychotropic medication report to the SWCM's supervisor who reviews the report before disseminating it to each SWCM.

The juvenile court services (JCS) quarterly psychotropic medication report is similar in structure and content as the DHS quarterly report. The Chief JCO ensures their quarterly report gets to the appropriate JCO supervisors who review them prior to disseminating to each JCO.

The psychotropic medication report (Attachment 8B(1)) outlines the response expectations for SWCMs and JCOs, which central office staff sends to the local office for regular follow-up. Staff has the responsibility to ensure the mental health needs of children in out-of-home care are met, including the oversight of medication prescribed for mental health. Appropriate oversight includes, but is not limited to:

- Ensuring that a child sees regularly a physician or psychiatrist to monitor the effectiveness of the medication, assess any side effects and/or health implications, consider any changes needed to dosage or medication type, and determine whether medication is still necessary and/or if other treatment options would be more appropriate.
- Regularly following up with foster parents/caregivers about administering medications appropriately, and about the child's experience with the medication(s), including any side effects.

Oversight of the medication by the worker requires teamwork, including coordination and communication amongst caregivers, service providers, parents, medical/mental health providers and, when appropriate, the child. DHS encourages parental involvement in decision-making to the greatest extent possible. When the worker receives the medication report, they are to verify that it is accurate and reflects the current medications of the child. The worker documents in the case narrative if the medication is working well, if there are any side effects, or if the child or others report concerns about the medication. Workers may also consult the child's physician, pharmacist, or the National Institutes of Health's Drug Information website. In addition, if appropriate, the worker advocates on the child's behalf to have the medications reviewed by the physician and explore alternatives. The worker places the medication report in the case file and any corresponding case management activities documented in the visitation notes or contact notes.

These quarterly psychotropic medication reports along with the Drug Utilization Review (DUR) Commission letters to providers contributed to the lowering of the usage of psychotropic medication. The DUR Commission examines the use of multiple antipsychotics and sends notification letters to prescribers and pharmacies stating they identified a member as having a drug related issue and makes a suggestion regarding medication therapy. Currently, based upon 6 months of pharmacy claims data, the DUR Commission sends the provider notification letters only to Medicaid fee-for-service providers. The DUR Commission sends these letters to providers that meet a certain set of criteria, either through regular profile reviews (which consist of 1,800 profiles over a 12 month period) or a targeted intervention (specific population, member count varies). The DUR does not send letters to **all** prescribers who prescribe two or more psychotropic agents simultaneously. Additionally, the DUR reviews 300 member (of all ages) profiles identified with the highest level of risk for a drug related issue at each

meeting; a small portion is for children for whom not all are on psychotropic medications.

Shared Decision-Making (Informed Consent and Assent)
DHS is starting the process of reviewing policy, practice, and procedure around informed consent and assent for the prescribing of psychotropic medications for children and youth in foster care. DHS is forming a workgroup to review the current process for obtaining and documenting shared decision-making. One objective for this workgroup will include developing a consent for psychotropic medication form to document diagnosis, proposed medication, expected benefits, possible risks/side effects, red flag information, and alternate treatment options. Signatures on the proposed form would indicate that review of the above information occurred with and consent obtained from the parent or legal guardian as well as assent obtained from the youth.

Response to U.S. Health and Human Services, Office of Inspector General (OIG) Report
Stakeholder Workgroup
In the summer/fall of 2020, the DHS plans to engage internal and external stakeholders, including pediatricians, other experts in health care, and experts in and recipients of child welfare services, in a robust discussion of Iowa's Health Care Oversight and Coordination Plan to:

- discuss and develop better treatment planning and medication monitoring for children in foster care with mental health disorders;
- discuss and further develop, if necessary, efforts to ensure that children entering foster care are not misdiagnosed with disorders that would result in non-foster family home placements; and
- evaluate more fully Iowa's current Health Care Oversight and Coordination Plan for potential improvements.

DHS originally planned this stakeholder workgroup for the fall of 2019. DHS on-boarded a new Program Manager was in October of 2019 and conducted a thorough review of the OIG Report, the Health Care Oversight and Coordination Plan, and current DHS policy and practice. The Program Manager determined that data was needed prior to moving forward in order to feed key decision points and to track the impact of any policy changes implemented as a result of a stakeholder workgroup. DHS is working with Iowa Medicaid Enterprise to obtain the identified data.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
All children in foster care enrolled in Medicaid are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Iowa has an EPSDT Care for Kids stakeholder workgroup comprising representatives from IME, Iowa Department of Public Health, managed care organizations (MCOs), and the University of Iowa. This workgroup focuses on the benefits, coverage, and education around the EPSDT for all Medicaid children.

The IME completes the required annual EPSDT Participation Report that reflects all eligible participants. However, the Report does not delineate the foster care population.

The last annual EPSDT report was for fiscal year 2017. This report shows all eligible individuals for EPSDT, the state periodicity schedule, age groups, the expected number of screenings per eligible and total screenings received, categorized into two eligibility groups of Categorically Needy (CN) and Medically Needy (MN).

DHS child welfare staff also is working with IME to pull out of the Core Set of Children's Health Care Quality Measures for the foster care population. Child welfare staff will utilize the child core set to assist us in monitoring the physical health, behavioral/mental health, and dental health care of children in foster care. IME recently upgraded its information system allowing for information specifically on the foster care population separate from the general Medicaid population. Child welfare staff anticipate development of an information sharing process over FFY 2021 with full implementation starting no later than FFY 2022.

Workforce

The 2019 legislative session approved additional funds to hire more child protective workers (CPWs) and SWCMs. DHS hopes that this will help lower some of the high caseloads of SWCMs thereby enabling them to complete treatment plans for all children in foster care and to monitor better their medications and their physical and mental health at their monthly visits with the children.

The DHS is in the process of updating our employee manual, with projected publish date of July 2020. Due to change in personnel, there was a delay from the original publication date of September of 2019. The employee manual will combine policy, practice, and procedures into one program manual to eliminate duplication. Additionally, it will include revisions to policy, practice, and procedure since the last published updates. The case management manual includes a new section on monitoring medications of children in foster care (Attachment 8B(2)), as well as Parent Partners, family-centered services (FCS), family team decision-making (FTDM) meetings and youth transition decision-making (YTDM) meetings not currently in the manual.

How Iowa actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

DHS' SWCMs assess the physical, dental, and mental health, and substance abuse needs, if applicable, of children in foster care. SWCMs consult with physicians or other appropriate medical or non-medical professionals for initial and ongoing medical exams, mental health evaluations, substance abuse evaluations, and necessary follow-up treatment, if determined needed by the health professional. DHS' SWCMs also participate in joint treatment planning conferences (JTPC) with DHS field operations support unit (FOSU) staff, DHS Mental Health and Disability Services (MHDS) staff, and medical professionals to discuss complex cases in an effort to ensure that children in foster care receive the most appropriate services for their needs. SWCMs submit a request for a JTPC, which includes the following information in the request:

- Name of child

- State ID
- Date of birth
- Summary of the child's current situation and the purpose of the call. (Please keep in mind that the calls are not intended to discuss funding issues, level of care decisions, etc. The call's focus is on the need for case management and assistance in setting up services to support the child and family.)
- List of names, phone numbers, and email for each of the individuals invited to the call.

The SWCM sends the request to a dedicated staff person located in the Bureau of Service Support and Training.

Outline the procedures and protocols the State established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.

When children placed in foster care come into the child welfare system, SWCMs look for the nearest care provider in order to continue their medical home and their existing treatment plans. DHS staff completed and submitted pre-file language for the Iowa 2019 legislative session, to include in the child's case plan documentation of:

- Efforts to retain professional providers for children entering/in foster care and
- Activities to evaluate service needs in order to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities.

The 2019 legislative session resulted in amending Iowa Code § 232.2, Definition of "case permanency plan" to add plans for retaining any suitable existing medical, dental, or mental health care providers of the child when the child enters foster care. House File 644 (Attachment 8B(3)) also required DHS to amend its administrative rules. The administrative rules provide that a case permanency plan for a child placed in foster care shall include information describing efforts to maintain suitable mental health care and medical health care for the child to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities. The DHS is in the process of changing the administrative rules to reflect the amended law. In January 2020, DHS submitted an amendment to IAC 441-202.1(234) to add the following language to the definition of case permanency plan:

> *"this includes information describing efforts to retain existing medical and mental health care providers for a child entering foster care and activities to evaluate service needs to avoid inappropriate diagnosis of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities."*

The Iowa Administrative Rules Review Committee adjusted its work in response to the Coronavirus pandemic, which delayed enactment of the administrative rule change. DHS anticipates that this administrative rule change will occur by early December 2020.

DHS added to the case plan an emphasis on keeping children with their current health care providers to mitigate misdiagnosis, in conjunction with the changes made to the case plan for transition planning noted below. For example, DHS added the following question on the Health Records section of the Records tab:

- "Was the child able to maintain current health care provider (mental, physical, dental)?"
    - "If no, describe efforts made to maintain continuity of care":

Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.
Iowa utilizes the streamlined procedure for youth automatically continuing on Medicaid; used previously for the Medicaid for Independent Young Adults (MIYA) program (reviewing first for any other Medicaid coverage groups the youth may be eligible for), once their foster care case closes. Extended Medicaid for Independent Young Adults (E-MIYA) uses a passive annual review to ensure location of the participant and any changes in household, which may make the participant eligible for other Medicaid coverage groups rather than E-MIYA.

The DHS transition planning specialists train workers on educating youth on the review procedure prior to discharge from care. Additionally, Aftercare workers and foster families received information on the procedure to assist those youth on their caseload with the review process. DHS stresses the reapplication process in new worker training. Youth automatically placed on E-MIYA or any other type of Medicaid coverage group at the point of discharge receive a letter from the DHS explaining the Medicaid coverage and the renewal process. Aftercare staff continues to receive monthly lists of youth participating in the Aftercare program who have a Medicaid annual review due the following month. This process greatly enhances youth participating in the Aftercare program to have continued Medicaid coverage.

In 2017, the Service Business Team (SBT), as planned, developed a written charter that identified goals, objectives and membership of a workgroup to evaluate and make recommendations for necessary and desired enhancements to the Transition Plan sections of the case permanency plan.

A workgroup (12 members) convened in early 2018. The workgroup capitalized on combined experience from child welfare policy, field social work, information systems, and juvenile justice. Information technology (IT) experts explained how and if desired changes may occur to the information systems. Supervisors and caseworkers attended. A foster care alumni representative captivated the team with her story. She was a great resource for the team, particularly during discussions about the real impacts and perceptions of case planning.

The workgroup completed their recommendations in March 2018. They successfully explored format changes and highlighted errors. They made recommendations for training structure and training content needed to implement changes. The workgroup facilitator captured the notes and formal recommendations of the workgroup, and then sent them to SBT for review and decision-making. SBT approved the changes recommended.

As a result of that workgroup's recommendations, a Transition Planning Tab became active in the Child Placement Plan (Part C of the case permanency plan) on February 25, 2020. A webinar occurred on January 14, 2020 to provide SWCMs and supervisors with training on the changes. The webinar remains on the DHS training website.

The health care needs of youth aging out of foster care were one of the five priority areas identified and improved for the new transition plan, including the requirements to include options for health insurance, information about a health care power of attorney, and a health care proxy. Because of new policy, DHS included more emphasis on keeping children with their current health care providers to mitigate misdiagnosis. On the Health Records section of the Records tab, for example, we added the following question.

- "Was the child able to maintain current health care provider (mental, physical, dental)?"
    - "If no, describe efforts made to maintain continuity of care":

Psychotropic Medication Report

You are receiving the attached report because one or more of your clients in out-of-home care:

1. Has been prescribed two or more psychotropic medications and/or
2. Is under the age of 6 and receiving at least one psychotropic medication

DHS has the responsibility to ensure the mental health needs of children in out-of-home care are met, including the oversight of medication prescribed for mental health. Appropriate oversight includes, but is not limited to:

- Ensuring that a child is seen regularly by a physician to monitor the effectiveness of the medication, assess any side effects and/or health implications, consider any changes needed to dosage or medication type, and determine whether medication is still necessary and/or if other treatment options would be more appropriate.
- Regularly following up with foster parents/caregivers about administering medications appropriately and about the child's experience with the medications(s), including any side effects.

Given increasing research regarding potential negative side effects of prescribing multiple psychotropic medications concurrently or for very young children, oversight is critical. Providing appropriate oversight of medication at the DHS worker level requires teamwork, including coordination and communication amongst DHS, caregivers, service providers, parents, medical/mental health providers, and when appropriate, the child. Parental involvement and decision-making should be encouraged to the greatest extent possible.

You are being asked to verify that the attached report accurately reflects the medications the child is currently taking. If the report is accurate:

- Does everything appear to be going well (e.g., are there adverse side effects, etc.)? Does the child or others report concerns about the medications?
- If you have questions regarding the medication and possible side effects, consult the child's physician, pharmacist, or the National Institutes of Health's Drug Information Website at **U.S. National Library of Medicine**.
- If appropriate, advocate on the child's behalf to have the medications reviewed by the physician and explore alternatives.
- Ensure the child's parents are aware.

Place the attached medication report in the case file and document any corresponding case management activities in Visitation Notes (under the Child Well-Being section) or Contact Notes.

If you have any questions, please contact the **Service Help Desk**.

Monitoring Health and Mental Health Care for Children in a Foster Care Placement

It is critical and federally mandated to monitor any health and mental health care needs of a foster child to ensure these needs are being met. Each foster child should be assessed by a clinician for their mental health needs and preferably a Pediatrician for their health care needs. SWCMs monitor any needs identified in these screenings through collateral contacts with providers, foster parents or QRTP staff, biological parents, and Department contractors. Most health care providers have electronic medical records. A foster care provider may ask for a "summary of the visit" or discharge/referral form at the end of a health care visit. If a health care provider does not have electronic medical records, the foster care provider should give the health care professional form *470-0580, Physical Record* to complete. SWCMs should review this and any other documentation regarding the child's health or mental health.

Monitoring health and mental health care is an ongoing process throughout the foster care placement. At each foster care monthly visit, the SWCM should ask for updates regarding any dental, medical, or mental health appointments as well as any recommendations or follow up resulting from these appointments.

The SWCM should document this information in the child's Face to Face and Contact Notes. All medical and mental health information should be included in any court report narrative, case narrative, and in the Case Permanency Plan.

Consenting to Medications

If the Department is the custodian of the child in a foster care placement, the SWCM should contact the child's parents or guardian to inform them of the medication recommendation. The best practice is to invite the child's parents or guardian to the child's evaluation or medical appointment. This enables the parents or guardian to directly ask the prescriber any questions they may have and to discuss any concerns. If the child's parents or guardian do not attend the evaluation or medical appointment, contact them and discuss the medication recommendation to obtain their consent. Foster care group care providers need to also discuss medication recommendations with the child's parents or guardian before the prescribed medication is obtained and given to the child.

When the Department is the guardian of the child in a foster care placement, the SWCM should discuss with their supervisor if they should consent to the recommended medication before the caregiver fills the medication prescription and administers it to the child.

Monitoring Medications

The SWCM needs to inquire of the caretaker at each visit as to over-the-counter and prescribed medications that have been administered to the child, including any negative reactions (side effects) to the medication by the child or if the medication is helping the child. Any medications, prescribed or over-the-counter, administered need to be documented in the case permanency plan, court report narrative, and the case narrative. Document the medication prescribed for the child, what the medication is prescribed for (e.g. diagnosis), and the dosage. Also document any new medication prescribed or if a medication changed.

In addition, the SWCM should ensure that a child is seen regularly by the prescribing physician or mental health professional to monitor the effectiveness of any medication, to assess any side effects, to monitor any health implications, to assess any needed medication changes, and to determine if the medication is still necessary or if other treatment options are more appropriate.

Ask the child if they have understand why they are taking medication and if they have any concerns about the medication. If there are concerns, you must advocate on the child's behalf to have the medications reviewed and explore alternatives to medication.

Addition information regarding medications maybe found at: http://www.nlm.nih.gov/medlineplus/druginformation.html

Monitoring Psychotropic Medication

Ensuring the appropriate use of psychotropic medication for children in foster care requires vigilant monitoring and oversight. Psychotropic medications are used to treat emotional and behavioral health symptoms and disorders. They primarily act on the central nervous system where they affect brain function, resulting in changes in perception, mood, consciousness, cognition, and behavior. Most children in foster care never need psychotropic medications. While they are traumatized by abuse and may show negative behaviors or signs of emotional stress, these are normal reactions to what they have been through. All children act out at different stages of their lives and most children will gradually heal in an appropriate environment and with consistent interventions.

However, the use of psychotropic medication in the foster care population is higher than in the general population. While some children may benefit from medication to treat certain mental health diagnoses, these medications may be harmful if used inappropriately. Medications do not treat trauma which is often triggering the emotions and behaviors. Working with a qualified mental health professional regarding trauma-informed mental health services is best

practice for addressing concerns without the inappropriate use of psychotropic medication.

Part of monitoring psychotropic medication involves being aware of "red flag" prescribing practices. These are practices that do not follow the recommended FDA guidelines for prescribing psychotropic medications to children. Red flag practices for prescribing psychotropic medications include:

- Prescribing multiple medications at the same time;
- Prescribing multiple medications before a trying a single medication;
- Prescribing to children under the age of 6; and/or
- Prescribing a dosage that exceeds recommendations.

The Department monitors the red flag practices of prescribing to children under the age of six and prescribing multiple medications at the same time through a quarterly report. This report is sent out to the social work administrators to distribute to the applicable supervisors and then to the SWCM. SWCM follow up to receiving information that a foster child on their caseload is in the report includes:

- Verifying that the report accurately reflects the psychotropic medications the child is taking;
- Verifying that appropriate and sufficient mental and behavioral health services were provided to the child before medication was prescribed;
- Verifying that other treatment options are being explored; and
- Verifying that physical and mental health monitoring is occurring as recommended for the medication prescribed.

The SWCM should then update the case file with current information and document all corresponding case management activities related to medication monitoring in the Face to Face and Contact Notes. A copy of the quarterly medication report should be placed in the child's file.

KIM REYNOLDS
GOVERNOR

OFFICE OF THE GOVERNOR

ADAM GREGG
LT GOVERNOR

May 10, 2019

The Honorable Paul Pate
Secretary of State of Iowa
State Capitol
Des Moines, Iowa 50319

Dear Mr. Secretary,

I hereby transmit:

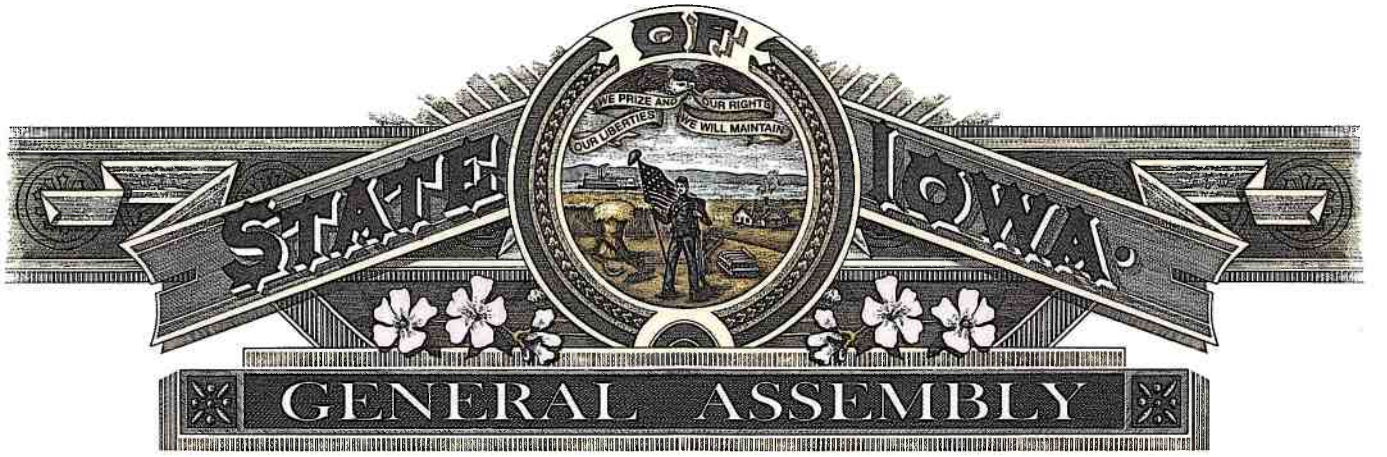
House File 644, an Act relating to juvenile justice, including provisions relating to child foster care and parent visitation in child in need of assistance proceedings.

The above House File is hereby approved on this date.

Sincerely,

Kim Reynolds
Governor of Iowa

cc: Secretary of the Senate
Clerk of the House



House File 644

AN ACT

RELATING TO JUVENILE JUSTICE, INCLUDING PROVISIONS RELATING TO CHILD FOSTER CARE AND PARENT VISITATION IN CHILD IN NEED OF ASSISTANCE PROCEEDINGS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 232.2, subsection 4, Code 2019, is amended by adding the following new paragraph:

NEW PARAGRAPH. *Of.* Plans for retaining any suitable existing medical, dental, or mental health providers providing medical, dental, or mental health care to the child when the child entered foster care.

Sec. 2. Section 232.2, subsection 4, paragraph f, subparagraph (7), Code 2019, is amended to read as follows:

(7) ~~Provision~~ The transition plan shall include a provision for the department or a designee of the department on or before the date the child reaches age eighteen, unless the child has been placed in foster care for less than thirty days, to provide to the child written verification of the child's foster care status, and a certified copy of the child's birth certificate, social security card, and driver's license or government-issued nonoperator's identification card. The fee for the certified copy of the child's birth certificate that is otherwise chargeable under section 144.13A, 144.46, or 331.605 shall be waived by the state or county registrar.

Sec. 3. Section 232.107, Code 2019, is amended to read as follows:

232.107 Parent visitation.

If a child is removed from the child's home in accordance with an order entered under this division ~~based upon evidence indicating the presence of an illegal drug in the child's body~~, unless the court finds that substantial evidence exists to believe that reasonable visitation or supervised visitation would cause an imminent risk to the child's life or health, the order shall allow the child's parent reasonable visitation or supervised visitation with the child.

Sec. 4. Section 237.1, subsection 4, paragraph f, Code 2019, is amended to read as follows:

f. Care furnished by a relative of a child ~~for more than twenty days in one calendar year,~~ or an individual person with a meaningful relationship with the child where the child is not under the placement, care, or supervision of the department.

Sec. 5. Section 237.8, subsection 2, paragraph a, subparagraphs (1) and (2), Code 2019, are amended to read as follows:

(1) If a person is being considered for licensure under this chapter, or for employment involving direct responsibility for a child or ~~with access to a child when the child is alone~~ in a facility where children reside, by a licensee under this chapter, or if a person will reside in a facility utilized by a licensee, and if the person has been convicted of a crime or has a record of founded child abuse, the department and the licensee for an employee of the licensee shall perform an evaluation to determine whether the crime or founded child abuse warrants prohibition of licensure, employment, or residence in the facility. The department shall conduct criminal and child abuse record checks in this state and may conduct these checks in other states. The evaluation shall be performed in accordance with procedures adopted for this purpose by the department.

(2) ~~For an individual~~ If an individual is being considered for licensure under this chapter, or for employment involving direct responsibility for a child or in a facility where children reside, by a licensee under this chapter, or if an individual will reside in a facility utilized by a licensee, or if an individual is subject to licensure under this chapter

as a foster parent, in addition to the record checks conducted under subparagraph (1), the individual's fingerprints shall be provided to the department of public safety for submission through the state criminal history repository to the United States department of justice, federal bureau of investigation for a national criminal history check. The cost of the criminal history check conducted under this subparagraph is the responsibility of the department of human services.

Sec. 6. Section 237.8, subsection 2, paragraph a, Code 2019, is amended by adding the following new subparagraphs:

NEW SUBPARAGRAPH. (02) If the criminal and child abuse record checks conducted in this state under subparagraph (1) for an individual being considered for licensure under this chapter, or for employment involving direct responsibility for a child or in a facility where children reside, by a licensee under this chapter, or for an individual who will reside in a facility utilized by a licensee, have been completed and the individual either does not have a record of crime or founded child abuse or the department's evaluation of the record has determined that prohibition of the individual's licensure or employment is not warranted, the individual may be provisionally approved for licensure or employment pending the outcome of the fingerprint-based criminal history check conducted pursuant to subparagraph (2).

NEW SUBPARAGRAPH. (002) An individual being considered for licensure under this chapter, or for employment involving direct responsibility for a child or in a facility where children reside, by a licensee under this chapter, or for an individual who will reside in a facility utilized by a licensee, shall not be granted a license or be employed and an evaluation shall not be performed under this subsection if the individual has been convicted of any of the following felony offenses:

(a) Within the five-year period preceding the application date, a drug-related offense.

(b) Child endangerment or neglect or abandonment of a dependent person.

(c) Domestic abuse.

(d) A crime against a child, including but not limited to

sexual exploitation of a minor.

(e) A forcible felony.

Sec. 7. DIRECTIVE TO DEPARTMENT OF HUMAN SERVICES — FOSTER CARE CASE PERMANENCY PLAN. The department of human services shall amend its administrative rules pursuant to chapter 17A to provide that a case permanency plan for a child placed in foster care shall include information describing efforts to maintain suitable mental health care and medical health care for the child to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, and developmental disabilities.

LINDA UPMEYER
Speaker of the House

CHARLES SCHNEIDER
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 644, Eighty-eighth General Assembly.

CARMINE BOAL
Chief Clerk of the House

Approved May 10th, 2019

KIM REYNOLDS
Governor