Confusion among Physicians
Regarding the Use of Psychotropic Medications

What Drugs Are We Talking About?

1) Medications in Florida Safe Families Network (FSFN) Psychotropic Medications Report, June 5, 2009 (Attachment 1)
   Note: also included are any "'Other' medication that is documented as having been prescribed for psychotropic purposes." "The list…should not be interpreted as an all inclusive list of psychotropic medications."

2) Okaloosa and Bay Counties List (Attachment 2)

3) Other References (e.g. WebMD in Escambia County)
   No listings for "Psychotropic" or "Psychotherapeutic"
   Listings for "Psychosis"
   No listing for "Oppositional Defiant Disorder"

What Conditions Are We Treating?

1) Department of Children and Families: For purposes of determining the need to seek informed consent or a court order and guiding the input of information into the Department's Florida Safe Families Network (FSFN) data system, psychotropic medication is defined as ***any chemical substance*** prescribed with the primary intent to treat **disturbances of reality testing, cognitive impairment, mood disorders and emotional dysregulation.** The medications include, without limitation, the following major categories:

(1) Antipsychotics
(2) Antidepressants
(3) Sedative Hypnotics
(4) Lithium
(5) Stimulants
(6) Non-stimulant Attention Deficit Hyperactivity Disorder medications
(7) Anti-dementia medications and cognition enhancers
(8) Anticonvulsants and alpha-2 agonists
(9) **Any other medication** used to stabilize or improve mood, mental status, behavior, or mental illness. (emphasis added)

Additionally, for purposes of determining the need to seek informed consent or a court order and guiding the input of information into the Department's FSFN system, psychotropic medication for the purposes of this definition includes such medication when used for **other medical purposes**.

2) Big Bend Community Based Care Policy & Procedure "Consent for Psychotropic Medication" p. 3, #2. (Attachment 3)

"I understand that a psychotropic medication means a prescription medication that is used for the treatment of **mental disorders** and includes, without limitation, antihypnotics, antipsychotics, antidepressants, anxiety agents, sedatives, psychomotor stimulants, and mood stabilizers." *(physician attestation)*

3) Treating Physician: (*personal communication*)

Per my D/W Judge here in ....., the operative word here is ***psychotropic***. If the child has a psychiatric/behavioral disorder/diagnosis and the medication is being used for psychotropic/behavioral modification purposes, the procedure for consent as contained in the Florida statue is to be followed. If the child has a seizure disorder/epilepsy and is being treated with an anticonvulsant medication for control of the seizures, it is NOT necessary to go through the process for psychotropic medication use (even if the drug is on the psychotropic medication "list").

The FSFN Psychotropic Medications list contains drugs used primarily to treat seizures, bed-wetting, and Tourette's.

Who Are We Serving?

F.S. 39.407 "Any child...removed from the home and maintained in an out-of-home placement..."

Children in Children's Medical Services (CMS) clinics typically are initially evaluated and treated, then reevaluated every 1-6 months depending on the stability of their condition. During those visits, their medical progress (or lack thereof) is documented, blood levels of medication (where appropriate) are determined and dosages are titrated as needed. Most importantly, "no-shows" are vigorously pursued.

Medical Homes for Children in Foster Care – *DRAFT* (Attachment 4)

Definition of Medical Home: Continual and comprehensive care that is managed and coordinated by a primary health care provider. Primary care is defined as comprehensive, first-contact, acute, chronic, and preventive care across the life span, delivered by a team of individuals lead by the patient's personal health care provider. The attributes of a medical home include

- Accessible care (nearby and timely);
- Available 24 hours a day through a means that allows for the rendering of clinical decision – and where the emergency room is not routinely used for regular care

- Ability to maintain primary health care provider without disruptions due to administrative procedures such as changes in assignment or breaks in eligibility
- Coordinated, including referral and scheduling of appointments that consider constraints of the family and are based on a treatment plan; the maintenance of all health information on the child and ability to transfer such information without difficulty. The use of a single comprehensive medical record, including a treatment plan is critical to the overall management of the child's care and reduction of patient errors.
- Comprehensive – preventive care, including health education and management of chronic illnesses either by the primary health care provider or in coordination with specialists and other health providers.
- Family-centered and culturally competent – This is a partnership between the medical home and the family and recognizes the culture the family comes from and lives in. The care is tailored to meet the needs and preferences of the families within the context of quality care.

<u>The four cornerstones of the medical home model are:</u>

1) Primary care,
2) Family-centered care
3) New-model practice (practice-site quality and efficiency improvements)
4) Payment reform. For the purposes of Florida's foster care system, we will focus on the first two cornerstones.

<u>Selection of a Medical Home:</u>

1. For the purposes of this project; each foster child (others?) shall have a primary care provider who meets the Children's Medical Services Network Credentialing Criteria. The providers are board-certified in pediatrics, family medicine, internal medicine (for children over the age of (?)16. ARNPs and Physician Assistants are also credentialed by the CMS Network as primary care providers.
2. A list of contracted programs, primary contacts, and a list of credentialed providers will be provided to DCF staff (? Appropriate term) to use in selecting primary care providers. All of the CMS Network providers currently accept Medicaid.
3. It is suggested that the foster care children who had been assigned to an HMO prior to placement remain with that HMO if it exists in the service area. Otherwise, the child shall be assigned to a MediPass provider in order to promote continuity of care if the child moves from foster home to foster home.
4. The CMS Primary Care Program and CMS provider liaisons are available to work with the DCF staff in recruiting additional providers.
5. The primary care provider will be assisted by health care coordinators.
6. To provide family-centered care for the foster child, the primary care provider, assisted by staff as needed, would include the foster family/ legal guardian, the case manager, and the birth parents (to the extent allowed), in medical decision making. This collaboration will not only occur in the office during the provision of care, but the primary care staff will communicate medical decisions to the foster child's case manager for dissemination to the birth family and inclusion in the case file as needed.

Minimum Criteria for Operation of the Medical Home:

1. All foster care children shall receive a comprehensive medical assessment through the primary care provider within 72 hours of placement (? real term) and a comprehensive behavioral assessment by a qualified professional within 96 hours of placement (? real term)
2. The primary care provider shall maintain a comprehensive medical record on the child that includes a treatment plan, medication list, medical supply list, allergies, and other important information that addresses the overall health status of the child and care of the child.
3. The care coordinator will assist with coordinating health care appointments and working with the DCF case manager.
4. If the child qualifies for the CMS Network based on a clinical screening, the family may be offered the choice of the CMS Network for the child's physical health care.
5. If the child qualifies for the Medical Foster Care Program, the operational procedures of the program will be applied (note: children in the medical foster care program are in the CMS Network).
6. Should the child's care be transferred to another primary care provider, the medical home team (physician and care coordinator), in coordination with the DCF case manager will be responsible for assuring that the medical information is complete and transferred quickly to another primary care provider.

Recommendations:

1) Treat the child, not the chart.

2) Treat the condition, not the drug list.

3) Consider that less physician paperwork may lead to greater patient care.

4) Improve foster parent training and observation skills

5) Remember the Chinese proverb:
Govern a family as you would cook a small fish-very gently.

Medications in FSFN:

Attachment 1

Abilify
Adderall
Alprazolam
Amitryptyline
Amoxapine
Amphetamine
Anafranil
Aripiprazole
Asendin
Ativan
Atomoxetine
Buprupion
Buspar
Buspirone
Carbamazepine
Celexa
Chlordiazepoxide
Chlorpromazine
Citalopram
Clomipramine
Clonazepam
Clozapine
Clozaril
Concerta
Cylert
Cymbalta
Dalmane
Depakene
Depakote
Desipramine
Desyrel
Dexedrine
Dexmethylphenidate
Dextroamphetamine
Diazepam
Divalproex Sodium
Doxepin
Duloxetine
Elavil
Escitalopram
Fluoxetine
Fluphenazine
Flurazepam
Fluvoxamine
Focalin
Gabapentin
Gabitril
Geodon
Halcion
Haldol
Haloperidol
Imipramine
Isocarboxazid
Keppra
Klonopin
Lamictal
Lamotrigine
Levetiracetam
Lexapro
Librium
Lithium
Lithobid; Eskalith
Lorazepam
Loxapine
Loxitane
Luvox
Marplan
Mellaril
Mesoridazine
Methylphenidate
Mirtazapine
Moban
Molindone
Nardil
Navane
Nefazodone
Neurontin
Norpramin; Pertofrane
Nortriptyline
Olanzapine
Orap (Pimozide)
Oxazepam
Oxcarbazepine
Pamelor; Aventyl
Parnate
Paroxetine
Paxil
Pemoline
Perphenazine
Phenelzine
Prolixin
Protriptyline
Prozac; Sarafam
Quetiapine
Remeron
Restoril
Risperdal
Risperidone
Ritalin
Serax
Serentil
Seroquel
Sertraline
Serzone
Sinequan
Stelazine
Straterra
Tegretol
Temazepam
Thioridazine
Thiothixene
Thorazine
Tiagabine
Tofranil
Topimax
Topiramate
Tranylcypromine
Trazodone
Triazolam
Trifluoperazine
Trilafon
Trileptal
Valium
Valproic Acid
Vivactil
Wellbutrin; Zyban
Xanax
Ziprasidone
Zoloft
Zolpidem
Zyprexa

Other Children's Psychotropic Medications:

Adderall XR
Cibalith-S
Effexor
Lithium Citrate
Metadate ER
Methylphenidate
Venlafaxine

Okaloosa and Bay County's Medication List

Attachment 2

Children's Psychotropic Medications

NAME	GENERIC NAME	TRADE NAME	AGE	TYPE
Adderall	amphetamine	Adderall	3 +	Stimulant
Adderall XR	Amphetamine (extended release)	Adderall XR	6 +	Stimulant
amphetamine	amphetamine	Adderall	3 +	Stimulant
Amphetamine (extended release)	Amphetamine (extended release)	Adderall XR	6 +	Stimulant
Anafranil	clomipramine	Anafranil	10 +	Antidepressant/ Antianxiety (for OCD)
atomoxetine	atomoxetine	Strattera	6 +	Non Stimulant for ADHD
bupropion	bupropion	Wellbutrin	18 +	Antidepressant/ Antianxiety
BuSpar	buspirone	BuSpar	18 +	Antidepressant/ Antianxiety
buspirone	buspirone	BuSpar	18 +	Antidepressant/ Antianxiety
carbamazepine	carbamazepine	Tegretol	any age	Mood Stabilizing (for seizures)
Cibalith-S	lithium citrate	Cibalith-S	12 +	Mood Stabilizing
clomipramine	clomipramine	Anafranil	10 +	Antidepressant/ Antianxiety (for OCD)
clozapine	clozapine	Clozaril (atypical)	18 +	Antipsychotic
Concerta	Methylphenidate (long acting)	Concerta	6 +	Stimulant
Cylert*	pemoline	Cylert*	6 +	Stimulant *Potential serious side effects - affecting liver - not ordinarily considered as 1st line drug therapy for ADHD.
Depakote	valproic acid	Depakote	2 +	Mood Stabilizing (for seizures)
Dexedrine	dextroamphetamine	Dexedrine	3 +	Stimulant
dexmethylphenidate	dexmethylphenidate	Focalin	6 +	Stimulant
dextroamphetamine	dextroamphetamine	Dexedrine	3 +	Stimulant
Dextrostat	dextroamphetamine	Dextrostat	3 +	Stimulant
doxepin	doxepin	Sinequan	12 +	Antidepressant/ Antianxiety
Effexor	venlafaxine	Effexor	18 +	Antidepressant/ Antianxiety

Eskalith	lithium carbonate	Eskalith	12 +	Mood Stabilizing
fluoxetine	fluoxetine	Prozac (SSRI)	18 +	Antidepressant/ Antianxiety
fluvoxamine	fluvoxamine	Luvox (SSRI)	8 +	Antidepressant-Antianxiety (for OCD)
Focalin	dexmethylphenidate	Focalin	6 +	Stimulant
Haldol	haloperidol	Haldol	3 +	Antipsychotic
haloperidol	haloperidol	Haldol	3 +	Antipsychotic
imipramine	imipramine	Tofranil	6 +	Antidepressant/ Antianxiety (for bedwetting)
lithium carbonate	lithium carbonate	Eskalith	12 +	Mood Stabilizing
lithium carbonate	lithium carbonate	Lithobid	12 +	Mood Stabilizing
lithium citrate	lithium citrate	Cibalith-S	12 +	Mood Stabilizing
Lithobid	lithium carbonate	Lithobid	12 +	Mood Stabilizing
Luvox (SSRI)	fluvoxamine	Luvox (SSRI)	8 +	Antidepressant/ Antianxiety (for OCD)
Mellaril	thioridazine	Mellaril	2 +	Antipsychotic
Metadate ER	methylphenidate (extended release)	Metadate ER	6 +	Stimulant
methylphenidate	methylphenidate	Ritalin	6 +	Stimulant
methylphenidate (extended release)	methylphenidate (extended release)	Metadate ER	6 +	Stimulant
Methylphenidate (long acting)	Methylphenidate (long acting)	Concerta	6 +	Stimulant
nefazodone	nefazodone	Serzone (SSRI)	18 +	Antidepressant/ Antianxiety
olanzapine	olanzapine	Zyprexa (atypical)	18 +	Antipsychotic
Orap	pimozide	Orap	12 +	Antipsychotic (for Tourette's syndrome -- Data for age 2+ indicate similar safety profile)
paroxetine	paroxetine	Paxil (SSRI)	18 +	Antidepressant/ Antianxiety
Paxil (SSRI)	paroxetine	Paxil (SSRI)	18 +	Antidepressant/ Antianxiety
pemoline	pemoline	Cylert*	6 +	Stimulant *Potential serious side effects - affecting liver - not ordinarily considered as 1st-line drug therapy for ADHD.

pimozide	pimozide	Orap	12 +	Antipsychotic (for Tourette's syndrome -- Data for age 2+ indicate similar safety profile)
Prozac (SSRI)	fluoxetine	Prozac (SSRI)	18 +	Antidepressant/ Antianxiety
quetiapine	quetiapine	Seroquel (atypical)	18 +	Antipsychotic
Risperdal (atypical)	risperidone	Risperdal (atypical)	18 +	Antipsychotic
risperidone	risperidone	Risperdal (atypical)	18 +	Antipsychotic
Ritalin	methylphenidate	Ritalin	6 +	Stimulant
Seroquel (atypical)	quetiapine	Seroquel (atypical)	18 +	Antipsychotic
sertraline	sertraline	Zoloft (SSRI)	6 +	Antidepressant-Antianxiety (for OCD)
Serzone (SSRI)	nefazodone	Serzone (SSRI)	18 +	Antidepressant/ Antianxiety
Sinequan	doxepin	Sinequan	12 +	Antidepressant/ Antianxiety
Strattera	atomoxetine	Strattera	6 +	Non-stimulant for ADHD
Tegretol	carbamazepine	Tegretol	any age	Mood Stabilizing (for seizures)
thioridazine	thioridazine	Mellaril	2 +	Antipsychotic
Tofranil	imipramine	Tofranil	6 +	Antidepressant-Antianxiety (for bedwetting)
valproic acid	valproic acid	Depakote	2 +	Mood Stabilizing (for seizures)
venlafaxine	venlafaxine	Effexor	18 +	Antidepressant/ Antianxiety
Wellbutrin	bupropion	Wellbutrin	18 +	Antidepressant/ Antianxiety
Zoloft (SSRI)	sertraline	Zoloft (SSRI)	6 +	Antidepressant-Antianxiety (for OCD)
Zyprexa (atypical)	olanzapine	Zyprexa (atypical)	18 +	Antipsychotic

* = benzodiazepine

Big Bend Community Based Care
Policy & Procedure

Series:	**300: Medical and Behavioral Health Care**
Policy Name:	**Consent for Psychotropic Medication**
Policy Number:	**301**
Origination Date:	**03/09/09** **Revision Date**
Regulation:	**39.407 F.S.** **65C-28.016 F.A.C.** **CFOP 175-98**
Attachments:	**Prescribing Physician's Medical Report,** **Express and Informed Parental Consent for the Administration of Psychotropic Medications**

Policy

It is the policy of BBCBC to mandate contracted CMOs ensure the proper administration of psychotropic medications to a child in the custody of the Department of Children and Families (DCF) will be completed only with the appropriate signed authorizations, according to clearly defined procedures for ongoing medication management and reviewed by a qualified physician.

Procedure

1. The administration of psychotropic medication to a child in the physical or temporary custody of DCF must have documented parental approval or Court ordered approval prior to administrating the medication, unless the attending physician considers the situation an emergency and documents in the medical record that the medication was needed to ensure the child's health and well being.

2. Upon learning that a child in the custody of DCF has a prescription for psychotropic medication the Dependency Case Manager (DCM) will obtain a Prescribing Physicians Medical Report (PPMR, see attached) and arrange for the parent and physician to discuss the treatment plan. The DCM will facilitate the parent and physician to complete, sign and date the Express and Informed Parental Consent for the Administration of Psychotropic Medication form (see attached), which will be filed with Children's Legal Services (CLS), and the Court.

3. If the parental rights of the parent have been terminated, the parent's location or identity is unknown or can not reasonably be ascertained, or the parent declines to give express and informed consent, the DCM, after consultation with the prescribing physician and obtaining a copy of the PPMR will seek assistance from CLS to obtain court authorization.

4. Psychotropic medications may be administered in advance of a court order in hospitals, Crisis Stabilization Units (CSU) and in Statewide Inpatient Psychiatric Programs (SIPP).

Within three (3) working days after the medication is initiated, Court authorization must be sought. See the attached form to be filed with the court

5. The parents will be notified as soon as possible after the treatment is initiated.

6. The assigned DCM is responsible for ensuring that that the caregivers are fully informed about the medication, possible side effects, and the proper administration, based on information provided by the prescribing physician.

7. The DCM will work with the CLS attorney to notify the court should there be any prescribed changes in medication, including brand name and dosage.

8. All administered psychotropic medications will be entered into FSFN by the DCM within 48 hours of the parental consent or Court approval of the medication. Updates, including changes in dosage or physician prescribed cessation of the medication will be added to FSFN within the same timeframe.

9. The DCM or other designee will attend medication reviews as required by the prescribing physician and/or agency.

10. Psychotropic medications will be dispensed by designated caregivers only.

11. If a child on psychotropic medication is removed from a foster placement and placed in another home it is the responsibility of the DCM transporting the child to obtain the current medication(s) in its bottle with original labeling and any additional written prescriptions and transport to the new placement.

Approved By:

_____ _____

Mike Watkins, Chief Executive Officer Date

EXPRESS AND INFORMED PARENTAL CONSENT FOR THE ADMINISTRATION OF PSYCHOTROPIC MEDICATION

CASE NO: _____

CHILD'S NAME: _____ **DOB:** _____

I, _____, am the Mother/Father of _____, and acknowledge that the following information has been provided and explained to me:

1. A psychotropic medication has been prescribed by a physician for my child _____. The medication(s) is/are: _____ _____, and is/are prescribed in the following dosage: _____.

2. I understand that a psychotropic medication means a prescription medication that is used for the treatment of mental disorders and includes, without limitation, antihypnotics, antipsychotics, antidepressants, anxiety agents, sedatives, psychomotor stimulants, and mood stabilizers.

3. I have been advised that my child is diagnosed with the following: _____, and have been advised of my child's symptoms and/or behaviors.

4. I have been provided the opportunity to consult with the prescribing physician or have been provided with the prescribing physician's medical report and the opportunity to consult with the prescribing physician or other qualified medical personnel.

5. I understand the reason for the treatment, the purpose of the treatment, and the nature of the proposed treatment. I have been advised as to the length of time my child may need to take the medication(s), and have been advised of alternative treatment modalities.

6. I have been informed of the side effects, risks, drug-interaction precautions, possible side effects of stopping the medication, and contraindications of the medication(s), and how treatment will be monitored.

7. I have been informed that the following additional medical, mental health, behavioral, counseling, or other services are recommended for my child:

   _____

   _____.

8. Pursuant to the provisions set forth in Fla. Stat. 39.407, I understand that I may revoke, either orally or in writing, my consent to this treatment at any time. I further understand that the Department of Children & Families and/or BBCBC has the right to obtain court authorization to continue this treatment should I withdraw my consent and that the medication(s) may continue to be administered pending the court hearing if the prescribing physician or such other qualified medical personnel determines that discontinuing the medication may cause significant harm to my child.

_____ _____
Date Physician (or designee)

_____ _____
Date Parent

Witnessed By:

_____ _____
Date Witness

Big Bend Community Based Care
Policy & Procedure

Child's Name: _____

DOB: _____

PRESCRIBING PHYSICIAN'S MEDICAL REPORT

I am a licensed physician in the State of Florida and pursuant to the provisions of Fla. Statute 39.407 recommend the following psychotropic medication(s) be administered to the child named herein, and in support of my recommendation state the following:

1. I have reviewed all medical information concerning the child which has been provided to me.

2. The child is diagnosed with the following _____
   _____

3. A description of the child's symptoms and/or behaviors is as follows:_____
   _____
   _____

4. I recommend the child be given the following medication(s):_____
   _____

5. I recommend the medication(s) listed in paragraph 3 above be administered in the following dosage: _____
   _____

6. The nature and purpose of the medication(s) is to treat the following:
   _____

7. I expect the child will need to take this medication for the following length of time:
   _____

8. Recognized side effects, risks, drug-interaction precautions, possible side effects of stopping the medication, and contraindications of the medication(s) are as follows:

_____

_____

_____

9. The medication prescribed herein will replace or supplement another currently prescribed medication(s) or treatment(s).

Yes_____ No _____

If yes, the following explanation is provided: _____

_____

10. The psychotropic medication listed in paragraph 2 at the dosage in paragraph 3 is appropriate for treatment of the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.

11. I recommend the following additional medical, mental health, behavioral, counseling, or other services be provided to the child:

_____

_____

12. The information contained in this report was explained to the child, if age appropriate, and to the child's caregiver.

13. If delay in providing the prescribed psychotropic medication would more likely than not cause significant harm to the child, the following specific reasons why the child may experience significant harm and the nature and extent of the potential harm is as follows: _____

_____

_____

Based upon the reasons stated, I recommend the medication be provided to the child in advance of the issuance of a court order. (The Department must submit a motion seeking continuation of the medication and the physician's medical report to the court, the child's guardian ad litem and all other parties within 3 working days after DCF commences providing the mediation to the child. The Department shall seek the order at the next regularly scheduled court hearing required under this chapter or within 30 days after the date of the prescription, whichever occurs sooner. If any party objects to DCF's motion, the court shall hold a hearing within 7 days).

Prescribing Physician's Name: _____

Prescribing Physician's Address: _____

Prescribing Physician's Specialty/Licensure: _____

_____
Prescribing Physician's Signature

_____
Date

PHYSICIAN'S AFFIDAVIT
REQUEST TO ADMINISTER PSYHOTROPIC MEDICATION

To Be Completed By Certifying Physician

(PLEASE WRITE LEGIBLY)

Reference: Chapter 39.407, Florida Statutes (2006)

I) I certify that, in my best professional judgment, there is a need to prescribe psychotropic medication for the child _____.

(Child's Name and Date of Birth)

II) Name of the psychotropic medication: _____.

III) Range of the prescribed dosage: _____.

IV) Diagnosed condition for which the medication is being prescribed: _____.

V) I have/have not (circle one) reviewed all medical information concerning the child which has been provided to me. If not, please explain:

_____

_____

_____

VI) The psychotropic medication prescribed, at its prescribed dosage, is appropriate to treat the child's diagnosed medical condition.

VII) A description of the behaviors and symptoms this medication, at its prescribed dosage, is expected to address is as follows:

_____

_____

_____

_____

_____

VIII) A description of the nature and purpose of the treatment; recognized side effects, risks, and contraindications of the medication; drug interaction precautions; the possible side effects of stopping the medications is as follows: (This information may be provided in an attachment).

_____

IX) The child's treatment will be monitored as follows:

(X) An explanation of the foregoing has/has not (circle one) been provided to the child, if age appropriate, and the child's caregiver. If no, please explain:

(XI) I am legally authorized to practice medicine/osteopathy in the State of Florida.

I declare under penalty of perjury that the foregoing is true and correct.

Signature of Physician

Date

Address of Physician:

PSYCHOTHERAPEUTIC MEDICATION TREATMENT PLAN

Prescribing Practitioner's Name:

Address:

Phone Number:

Child's Name:

Date/Time of Office Visit:

SECTION 1: DEMOGRAPHIC INFORMATION (to be completed by the Child Case Manager / Child Welfare Worker)

Child's Name: SSN: Date of Office Visit:

Address:

Child's Date of Birth: Age: DCF District/Region:

Case Manager/Child Welfare Staff: Phone Number:

Case Manager Supervisor: Phone Number:

DCF Contracted Agency: Fax Number:

Express and Informed Consent was obtained from the parent/guardian: ☐ YES ☐ NO Date:

If yes, name of person consenting: Relationship to Child:

If no, please explain:

Sections 2 through 5 are to be completed by the Prescribing Practitioner

SECTION 2: DIAGNOSIS / DISORDER / BEHAVIORAL HYPOTHESIS

☐ Depression ☐ Oppositional Defiant Disorder ☐ ADHD ☐ Anxiety Disorder

☐ Conduct Disorder ☐ Post Traumatic Stress Disorder ☐ Bipolar Disorder ☐ Mental Retardation

☐ Substance Abuse ☐ Reactive Attachment Disorder ☐ Autism/Asperger's ☐ Psychosis

☐ Learning Communication/Speech ☐ Other (specify):

☐ Rule Out:

I have reviewed all medical information concerning this child provided to me by DCF and/or the child's caregivers. I find that there is a need for this child to receive mental health treatment with psychotherapeutic medications based upon the diagnosed condition indicated above..... (Init.)

SECTION 3: PSYCHOTHERAPEUTIC MEDICATION PLANNED

Medication: Dose: Dosage Range:

Titration Plan:

Start Date: to address the following target symptoms (include nature and purpose of treatment):

Define treatment success/failure and expected length of treatment:

(continue Section 3 on next page)

Define monitoring plan (include frequency of planned monitoring):

This medication at its prescribed dosage is appropriate to treat the child's diagnosed condition. I have attached a document which includes the recognized side effects, risks and contraindications of this medication, drug-interaction precautions and the possible effects of stopping the medication.

I have provided a copy of this information to the child, if age appropriate, and to the child's caregiver. I have also discussed this information with the child, if age appropriate, and with the child's caregiver..... (Init.)

Delay in providing the prescribed psychotherapeutic medication would more likely than not cause significant harm to the child: ☐YES ☐NO

If yes, please explain:

SECTION 4: OTHER RECOMMENDED TREATMENTS/THERAPIES/EVALUATIONS/TESTS (Please list provider(s))

SECTION 5: MEDICAL PROBLEMS AND OTHER MEDICATIONS (including over-the-counter medications and medications that this prescription is intended to replace)

Signature of Prescribing Practitioner / Date

Comments of individual providing express and informed consent:

Signature of individual providing express and informed consent — Date

Adderall XR—Cont.

products generally should not be used in children or adolescents with known serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, or other serious cardiac problems that may place them at increased vulnerability to the sympathomimetic effects of a stimulant drug (see CONTRAINDICATIONS).

Adults

Sudden deaths, stroke, and myocardial infarction have been reported in adults taking stimulant drugs at usual doses for ADHD. Although the role of stimulants in these adult cases is also unknown, adults have a greater likelihood than children of having serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, coronary artery disease, or other serious cardiac problems. Adults with such abnormalities should also generally not be treated with stimulant drugs (see CONTRAINDICATIONS).

Hypertension and other Cardiovascular Conditions

Stimulant medications cause a modest increase in average blood pressure (about 2-4 mmHg) and average heart rate (about 3-6 bpm) [see ADVERSE EVENTS], and individuals may have larger increases. While the mean changes alone would not be expected to have short-term consequences, all patients should be monitored for larger changes in heart rate and blood pressure. Caution is indicated in treating patients whose underlying medical conditions might be compromised by increases in blood pressure or heart rate, e.g., those with pre-existing hypertension, heart failure, recent myocardial infarction, or ventricular arrhythmia (see CONTRAINDICATIONS).

Assessing Cardiovascular Status in Patients being Treated with Stimulant Medications

Children, adolescents, or adults who are being considered for treatment with stimulant medications should have a careful history (including assessment for a family history of sudden death or ventricular arrhythmia) and physical exam to assess for the presence of cardiac disease, and should receive further cardiac evaluation if findings suggest such disease (e.g. electrocardiogram and echocardiogram). Patients who develop symptoms such as exertional chest pain, unexplained syncope, or other symptoms suggestive of cardiac disease during stimulant treatment should undergo a prompt cardiac evaluation.

Psychiatric Adverse Events

Pre-Existing Psychosis

Administration of stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with pre-existing psychotic disorder.

Bipolar Illness

Particular care should be taken in using stimulants to treat ADHD patients with comorbid bipolar disorder because of concern for possible induction of mixed/manic episode in such patients. Prior to initiating treatment with a stimulant, patients with comorbid depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression.

Emergence of New Psychotic or Manic Symptoms

Treatment emergent psychotic or manic symptoms, e.g., hallucinations, delusional thinking, or mania in children and adolescents without prior history of psychotic illness or mania can be caused by stimulants at usual doses. If such symptoms occur, consideration should be given to a possible causal role of the stimulant, and discontinuation of treatment may be appropriate. In a pooled analysis of multiple short-term, placebo-controlled studies, such symptoms occurred in about 0.1% (4 patients with events out of 3482 exposed to methylphenidate or amphetamine for several weeks at usual doses) of stimulant-treated patients compared to 0 in placebo-treated patients.

Aggression

Aggressive behavior or hostility is often observed in children and adolescents with ADHD, and has been reported in clinical trials and the postmarketing experience of some medications indicated for the treatment of ADHD. Although there is no systematic evidence that stimulants cause aggressive behavior or hostility, patients beginning treatment for ADHD should be monitored for the appearance of or worsening of aggressive behavior or hostility.

Long-Term Suppression of Growth

Careful follow-up of weight and height in children ages 7 to 10 years who were randomized to either methylphenidate or non-medication treatment groups over 14 months, as well as in naturalistic subgroups of newly methylphenidate-treated and non-medication treated children over 36 months (to the ages of 10 to 13 years), suggests that consistently medicated children (i.e., treatment for 7 days per week throughout the year) have a temporary slowing in growth rate (on average, a total of about 2 cm less growth in height and 2.7 kg less growth in weight over 3 years), without evidence of growth rebound during this period of development. In a controlled trial of ADDERALL XR® in adolescents, mean weight change from baseline within the initial 4 weeks of therapy was –1.1 lbs. and –2.8 lbs., respectively, [illegible] 10 mg and 20 mg ADDERALL XR®. Therefore, growth should be monitored during treatment with stimulants, and patients who are not growing or gaining weight as expected may need to have their treatment interrupted.

Seizures

There is some clinical evidence that stimulants may lower the convulsive threshold in patients with prior history of seizure, in patients with prior EEG abnormalities in absence of seizures, and very rarely, in patients without a history of seizures and no prior EEG evidence of seizures. In the presence of seizures, the drug should be discontinued.

Visual Disturbance

Difficulties with accommodation and blurring of vision have been reported with stimulant treatment.

PRECAUTIONS

General: The least amount of amphetamine feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. ADDERALL XR® should be used with caution in patients who use other sympathomimetic drugs.

Tics: Amphetamines have been reported to exacerbate motor and phonic tics and Tourette's syndrome. Therefore, clinical evaluation for tics and Tourette's Syndrome in children and their families should precede use of stimulant medications.

Information for Patients: Amphetamines may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or vehicles; the patient should therefore be cautioned accordingly.

Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with amphetamine and should counsel them in its appropriate use. A patient Medication Guide is available for ADDERALL XR®. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. The complete text of the Medication Guide is reprinted at the end of this document.

Drug Interactions: *Acidifying agents*-Gastrointestinal acidifying agents (guanethidine, reserpine, glutamic acid HCl, ascorbic acid, etc.) lower absorption of amphetamines.

Urinary acidifying agents-These agents (ammonium chloride, sodium acid phosphate, etc.) increase the concentration of the ionized species of the amphetamine molecule, thereby increasing urinary excretion. Both groups of agents lower blood levels and efficacy of amphetamines.

Adrenergic blockers-Adrenergic blockers are inhibited by amphetamines.

Alkalinizing agents -Gastrointestinal alkalinizing agents (sodium bicarbonate, etc.) increase absorption of amphetamines. Co-administration of ADDERALL XR® and gastrointestinal alkalinizing agents, such as antacids, should be avoided. Urinary alkalinizing agents (acetazolamide, some thiazides) increase the concentration of the non-ionized species of the amphetamine molecule, thereby decreasing urinary excretion. Both groups of agents increase blood levels and therefore potentiate the actions of amphetamines.

Antidepressants, tricyclic -Amphetamines may enhance the activity of tricyclic antidepressants or sympathomimetic agents; d-amphetamine with desipramine or protriptyline and possibly other tricyclics cause striking and sustained increases in the concentration of d-amphetamine in the brain; cardiovascular effects can be potentiated.

MAO inhibitors -MAOI antidepressants, as well as a metabolite of furazolidone, slow amphetamine metabolism. This slowing potentiates amphetamines, increasing their effect on the release of norepinephrine and other monoamines from adrenergic nerve endings; this can cause headaches and other signs of hypertensive crisis. A variety of toxic neurological effects and malignant hyperpyrexia can occur, sometimes with fatal results.

Antihistamines -Amphetamines may counteract the sedative effect of antihistamines.

Antihypertensives -Amphetamines may antagonize the hypotensive effects of antihypertensives.

Chlorpromazine -Chlorpromazine blocks dopamine and norepinephrine receptors, thus inhibiting the central stimulant effects of amphetamines, and can be used to treat amphetamine poisoning.

Ethosuximide -Amphetamines may delay intestinal absorption of ethosuximide.

Haloperidol -Haloperidol blocks dopamine receptors, thus inhibiting the central stimulant effects of amphetamines.

Lithium carbonate -The anorectic and stimulatory effects of amphetamines may be inhibited by lithium carbonate.

Meperidine -Amphetamines potentiate the analgesic effect of meperidine.

Methenamine therapy -Urinary excretion of amphetamines is increased, and efficacy is reduced, by acidifying agents used in methenamine therapy.

Norepinephrine -Amphetamines enhance the adrenergic effect of norepinephrine.

Phenobarbital -Amphetamines may delay intestinal absorp-

Propoxyphene -In cases of propoxyphene overdosage, amphetamine CNS stimulation is potentiated and fatal convulsions can occur.

Veratrum alkaloids -Amphetamines inhibit the hypotensive effect of veratrum alkaloids.

Drug/Laboratory Test Interactions: Amphetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amphetamines may interfere with urinary steroid determinations.

Carcinogenesis/Mutagenesis and Impairment of Fertility: No evidence of carcinogenicity was found in studies in which d,l-amphetamine (enantiomer ratio of 1:1) was administered to mice and rats in the diet for 2 years at doses of up to 30 mg/kg/day in male mice, 19 mg/kg/day in female mice, and 5 mg/kg/day in male and female rats. These doses are approximately 2.4, 1.5, and 0.8 times, respectively, the maximum recommended human dose of 30 mg/day [child] on a mg/m^2 body surface area basis.

Amphetamine, in the enantiomer ratio present in ADDERALL® (immediate-release)(d- to l-ratio of 3:1), was not clastogenic in the mouse bone marrow micronucleus test *in vivo* and was negative when tested in the E. coli component of the Ames test *in vitro*. d,l-Amphetamine (1:1 enantiomer ratio) has been reported to produce a positive response in the mouse bone marrow micronucleus test, an equivocal response in the Ames test, and negative responses in the *in vitro* sister chromatid exchange and chromosomal aberration assays.

Amphetamine, in the enantiomer ratio present in ADDERALL® (immediate-release)(d- to l-ratio of 3:1), did not adversely affect fertility or early embryonic development in the rat at doses of up to 20 mg/kg/day (approximately 5 times the maximum recommended human dose of 30 mg/day on a mg/m^2 body surface area basis).

Pregnancy: Pregnancy Category C. Amphetamine, in the enantiomer ratio present in ADDERALL® (d- to l-ratio of 3:1), had no apparent effects on embryofetal morphological development or survival when orally administered to pregnant rats and rabbits throughout the period of organogenesis at doses of up to 6 and 16 mg/kg/day, respectively. These doses are approximately 1.5 and 8 times, respectively, the maximum recommended human dose of 30 mg/day [child] on a mg/m^2 body surface area basis. Fetal malformations and death have been reported in mice following parenteral administration of d-amphetamine doses of 50 mg/kg/day (approximately 6 times that of a human dose of 30 mg/day [child] on a mg/m^2 basis) or greater to pregnant animals. Administration of these doses was also associated with severe maternal toxicity.

A number of studies in rodents indicate that prenatal or early postnatal exposure to amphetamine (d- or d,l-), at doses similar to those used clinically, can result in long-term neurochemical and behavioral alterations. Reported behavioral effects include learning and memory deficits, altered locomotor activity, and changes in sexual function.

There are no adequate and well-controlled studies in pregnant women. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (vater association) in a baby born to a woman who took dextroamphetamine sulfate with lovastatin during the first trimester of pregnancy. Amphetamines should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Infants born to mothers dependent on amphetamines have an increased risk of premature delivery and low birth weight. Also, these infants may experience symptoms of withdrawal as demonstrated by dysphoria, including agitation, and significant lassitude.

Usage in Nursing Mothers: Amphetamines are excreted in human milk. Mothers taking amphetamines should be advised to refrain from nursing.

Pediatric Use: ADDERALL XR® is indicated for use in children 6 years of age and older.

Use in Children Under Six Years of Age: Effects of ADDERALL XR® in 3-5 year olds have not been studied. Long-term effects of amphetamines in children have not been well established. Amphetamines are not recommended for use in children under 3 years of age.

Geriatric Use: ADDERALL XR ® has not been studied in the geriatric population.

ADVERSE EVENTS

Hypertension: [See WARNINGS section] In a controlled 4-week outpatient clinical study of adolescents with ADHD, isolated systolic blood pressure elevations ≥15 mmHg were observed in 7/64 (11%) placebo-treated patients and 7/100 (7%) patients receiving ADDERALL XR® 10 or 20 mg. Isolated elevations in diastolic blood pressure ≥ 8 mmHg were observed in 16/64 (25%) placebo-treated patients and 22/100 (22%) ADDERALL XR®-treated patients. Similar results were observed at higher doses.

In a single-dose pharmacokinetic study in 23 adolescents, isolated increases in systolic blood pressure (above the upper 95% CI for age, gender and stature) were observed in 2/17 (12%) and 8/23 (35%), subjects administered 10 mg and 20 mg ADDERALL XR®, respectively. Higher single doses were associated with a greater increase in systolic blood pressure. All increases were transient, appeared maximal at 2 to 4 hours post dose and not associated with symptoms.

trolled clinical studies, one open-label clinical study, and two single-dose clinical pharmacology studies (N=40). Safety data on all patients are included in the discussion that follows. Adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and listings that follow, COSTART terminology has been used to classify reported adverse events.

The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed.

Adverse events associated with discontinuation of treatment: In two placebo-controlled studies of up to 5 weeks duration among children with ADHD, 2.4% (10/425) of ADDERALL XR® treated patients discontinued due to adverse events (including 3 patients with loss of appetite, one of whom also reported insomnia) compared to 2.7% (7/259) receiving placebo. The most frequent adverse events associated with discontinuation of ADDERALL XR® in controlled and uncontrolled, multiple-dose clinical trials of pediatric patients (N=595) are presented below. Over half of these patients were exposed to ADDERALL XR® for 12 months or more.

Adverse event	% of pediatric patients discontinuing (n=595)
Anorexia (loss of appetite)	2.9
Insomnia	1.5
Weight loss	1.2
Emotional lability	1.0
Depression	0.7

In a separate placebo-controlled 4-week study in adolescents with ADHD, eight patients (3.4%) discontinued treatment due to adverse events among ADDERALL XR®-treated patients (N=233). Three patients discontinued due to insomnia and one patient each for depression, motor tics, headaches, light-headedness, and anxiety.

In one placebo-controlled 4-week study among adults with ADHD, patients who discontinued treatment due to adverse events among ADDERALL XR®-treated patients (N=191) were 3.1% (n=6) for nervousness including anxiety and irritability, 2.6% (n=5) for insomnia, 1% (n=2) each for headache, palpitation, and somnolence; and, 0.5% (n=1) each for ALT increase, agitation, chest pain, cocaine craving, elevated blood pressure, and weight loss.

Adverse events occurring in a controlled trial: Adverse events reported in a 3-week clinical trial of pediatric patients and a 4-week clinical trial in adolescents and adults, respectively, treated with ADDERALL XR® or placebo are presented in the tables below.

The prescriber should be aware that these figures cannot be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied.

[See table 1 above]

[See table 2 above]

[See table 3 above]

The following adverse reactions have been associated with the use of amphetamine, ADDERALL XR®, or ADDERALL®:

Cardiovascular: Palpitations, tachycardia, elevation of blood pressure, sudden death, myocardial infarction. There have been isolated reports of cardiomyopathy associated with chronic amphetamine use.

Central Nervous System: Psychotic episodes at recommended doses, overstimulation, restlessness, dizziness, insomnia, euphoria, dyskinesia, dysphoria, depression, tremor, headache, exacerbation of motor and phonic tics and Tourette's syndrome, seizures, stroke.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances. Anorexia and weight loss may occur as undesirable effects.

Allergic: Urticaria, rash, hypersensitivity reactions including angioedema and anaphylaxis. Serious skin rashes, including Stevens Johnson Syndrome and toxic epidermal necrolysis have been reported.

Endocrine: Impotence, changes in libido.

DRUG ABUSE AND DEPENDENCE

ADDERALL XR® is a Schedule II controlled substance.

Table 1 Adverse Events Reported by More Than 1% of Pediatric Patients Receiving ADDERALL XR® with Higher Incidence Than on Placebo in a 584 Patient Clinical Study

Body System	Preferred Term	ADDERALL XR® (n=374)	Placebo (n=210)
General	Abdominal Pain (stomachache)	14%	10%
	Accidental Injury	3%	2%
	Asthenia (fatigue)	2%	0%
	Fever	5%	2%
	Infection	4%	2%
	Viral Infection	2%	0%
Digestive System	Loss of Appetite	22%	2%
	Diarrhea	2%	1%
	Dyspepsia	2%	1%
	Nausea	5%	3%
	Vomiting	7%	4%
Nervous System	Dizziness	2%	0%
	Emotional Lability	9%	2%
	Insomnia	17%	2%
	Nervousness	6%	2%
Metabolic/Nutritional	Weight Loss	4%	0%

Table 2 Adverse Events Reported by 5% or more of Adolescents Weighing ≤ 75 kg/165 lbs Receiving ADDERALL XR® with Higher Incidence Than Placebo in a 287 Patient Clinical Forced Weekly-Dose Titration Study*

Body System	Preferred Term	ADDERALL XR® (n=233)	Placebo (n=54)
General	Abdominal Pain (stomachache)	11%	2%
Digestive System	Loss of Appetite[b]	36%	2%
Nervous System	Insomnia[b]	12%	4%
	Nervousness	6%	6%[a]
Metabolic/Nutritional	Weight Loss[b]	9%	0%

[a] Appears the same due to rounding

[b] Dose-related adverse events

Note: The following events did not meet the criterion for inclusion in Table 2 but were reported by 2% to 4% of adolescent patients receiving ADDERALL XR with a higher incidence than patients receiving placebo in this study: accidental injury, asthenia (fatigue), dry mouth, dyspepsia, emotional lability, nausea, somnolence, and vomiting.

*Included doses up to 40 mg

Table 3 Adverse Events Reported by 5% or More of Adults Receiving ADDERALL XR® with Higher Incidence Than on Placebo in a 255 Patient Clinical Forced Weekly-Dose Titration Study*

Body System	Preferred Term	ADDERALL XR® (n=191)	Placebo (n=64)
General	Asthenia	6%	5%
	Headache	26%	13%
Digestive System	Loss of Appetite	33%	3%
	Diarrhea	6%	0%
	Dry Mouth	35%	5%
	Nausea	8%	3%
Nervous System	Agitation	8%	5%
	Anxiety	8%	5%
	Dizziness	7%	0%
	Insomnia	27%	13%
Cardiovascular System	Tachycardia	6%	3%
Metabolic/Nutritional	Weight Loss	11%	0%
Urogenital System	Urinary Tract Infection	5%	0%

Note: The following events did not meet the criterion for inclusion in Table 3 but were reported by 2% to 4% of adult patients receiving ADDERALL XR® with a higher incidence than patients receiving placebo in this study: infection, photosensitivity reaction, constipation, tooth disorder, emotional lability, libido decreased, somnolence, speech disorder, palpitation, twitching, dyspnea, sweating, dysmenorrhea, and impotence.

*Included doses up to 60 mg.

dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with amphetamines may include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

OVERDOSAGE

Individual patient response to amphetamines varies widely. Toxic symptoms may occur idiosyncratically at low doses.

Symptoms: Manifestations of acute overdosage with amphetamines include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states, hyperpyrexia and rhabdomyolysis. Fatigue and depression usually follow the central nervous system

Treatment: Consult with a Certified Poison Control Center for up to date guidance and advice. Management of acute amphetamine intoxication is largely symptomatic and includes gastric lavage, administration of activated charcoal, administration of a cathartic and sedation. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases amphetamine excretion, but is believed to increase risk of acute renal failure if myoglobinuria is present. If acute severe hypertension complicates amphetamine overdosage, administration of intravenous phentolamine has been suggested. However, a gradual drop in blood pressure will usually result when sufficient sedation has been achieved. Chlorpromazine antagonizes the central stimulant effects of amphetamines and can be used to treat amphetamine intoxication.

The prolonged release of mixed amphetamine salts from

Medical Homes for Children in Foster Care – DRAFT (Attachment 4)

Definition of Medical Home:
Continual and comprehensive care that is managed and coordinated by a primary health care provider. Primary care is defined as comprehensive, first-contact, acute, chronic, and preventive care across the life span, delivered by a team of individuals lead by the patient's personal health care provider. The attributes of a medical home include:

- Accessible care (nearby and timely);
- Available 24 hours a day through a means that allows for the rendering of clinical decision – and where the emergency room is not routinely used for regular care
- Ability to maintain primary health care provider without disruptions due to administrative procedures such as changes in assignment or breaks in eligibility
- Coordinated, including referral and scheduling of appointments that consider constraints of the family and are based on a treatment plan; the maintenance of all health information on the child and ability to transfer such information without difficulty. The use of a single comprehensive medical record, including a treatment plan is critical to the overall management of the child's care and reduction of patient errors.
- Comprehensive – preventive care, including health education and management of chronic illnesses either by the primary health care provider or in coordination with specialists and other health providers.
- Family-centered and culturally competent – This is a partnership between the medical home and the family and recognizes the culture the family comes from and lives in. The care is tailored to meet the needs and preferences of the families within the context of quality care.

The four cornerstones of the medical home model are:
primary care, family-centered care, new-model practice (practice-site quality and efficiency improvements), and payment reform. For the purposes of Florida's foster care system, we will focus on the first two cornerstones.

Selection of a Medical Home:

1. For the purposes of this project; each foster child (others?) shall have a primary care provider who meets the Children's Medical Services Network Credentialing Criteria. The providers are board-certified in pediatrics, family medicine, internal medicine (for children over the age of ?16). ARNPs and Physician Assistants are also credentialed by the CMS Network as primary care providers.

2. A list of contracted programs, primary contacts, and a list of credentialed providers will be provided to DCF staff (? Appropriate term) to use in selecting primary care providers. All of the CMS Network providers currently accept Medicaid.
3. It is suggested that the foster care children who had been assigned to an HMO prior to placement remain with that HMO if it exists in the service area. Otherwise, the child shall be assigned to a MediPass provider in order to promote continuity of care if the child moves from foster home to foster home.
4. The CMS Primary Care Program and CMS provider liaisons are available to work with the DCF staff in recruiting additional providers.
5. The primary care provider will be assisted by health care coordinators.
6. To provide family-centered care for the foster child, the primary care provider, assisted by staff as needed, would include the foster family/ legal guardian, the case manager, and the birth parents (to the extent allowed), in medical decision making. This collaboration will not only occur in the office during the provision of care, but the primary care staff will communicate medical decisions to the foster child's case manager for dissemination to the birth family and inclusion in the case file as needed.

<u>Minimum Criteria for Operation of the Medical Home:</u>

1. All foster care children shall receive a comprehensive medical assessment through the primary care provider within 72 hours of placement (? Real term) and a comprehensive behavioral assessment by a qualified professional within 96 hours of placement (?real term)
2. The primary care provider shall maintain a comprehensive medical record on the child that includes a treatment plan, medication list, medical supply list, allergies, and other important information that addresses the overall health status of the child and care of the child.
3. The care coordinator will assist with coordinating health care appointments and working with the DCF case manager.
4. If the child qualifies for the CMS Network based on a clinical screening, the family may be offered the choice of the CMS Network for the child's physical health care.
5. If the child qualifies for the Medical Foster Care Program, the operational procedures of the program will be applied (note: children in the medical foster care program are in the CMS Network).
6. Should the child's care be transferred to another primary care provider, the medical home team (physician and care coordinator), in coordination with the DCF case manager will be responsible for assuring that the medical information is complete and transferred quickly to another primary care provider.