SENATE AMENDMENTS

2nd Printing

By: Kolkhorst, N. Gonzalez of El Paso, Burkett, Naishtat, Dukes, et al. H.B. No. 915

A BILL TO BE ENTITLED

AN ACT

relating to the administration and monitoring of health care provided to foster children.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 107.002, Family Code, is amended by adding Subsection (b-1) to read as follows:

(b-1) In addition to the duties required by Subsection (b), a guardian ad litem appointed for a child in a proceeding under Chapter 262 or 263 shall:

(1) review the medical care provided to the child; and

(2) in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided.

SECTION 2. Section 107.003, Family Code, is amended to read as follows:

Sec. 107.003. POWERS AND DUTIES OF ATTORNEY AD LITEM FOR CHILD AND AMICUS ATTORNEY. (a) An attorney ad litem appointed to represent a child or an amicus attorney appointed to assist the court:

(1) shall:

(A) subject to Rules 4.02, 4.03, and 4.04, Texas Disciplinary Rules of Professional Conduct, and within a reasonable time after the appointment, interview:

(i) the child in a developmentally appropriate manner, if the child is four years of age or older;

(ii) each person who has significant knowledge of the child's history and condition, including any foster parent of the child; and

(iii) the parties to the suit;

(B) seek to elicit in a developmentally appropriate manner the child's expressed objectives of representation;

(C) consider the impact on the child in formulating the attorney's presentation of the child's expressed objectives of representation to the court;

(D) investigate the facts of the case to the extent the attorney considers appropriate;

(E) obtain and review copies of relevant records relating to the child as provided by Section 107.006;

(F) participate in the conduct of the litigation to the same extent as an attorney for a party;

(G) take any action consistent with the child's interests that the attorney considers necessary to expedite the proceedings;

(H) encourage settlement and the use of alternative forms of dispute resolution; and

(I) review and sign, or decline to sign, a proposed or agreed order affecting the child;

(2) must be trained in child advocacy or have experience determined by the court to be equivalent to that training; and

(3) is entitled to:

(A) request clarification from the court if the role of the attorney is ambiguous;

(B) request a hearing or trial on the merits;

(C) consent or refuse to consent to an interview of the child by another attorney;

(D) receive a copy of each pleading or other paper filed with the court;

(E) receive notice of each hearing in the suit;

(F) participate in any case staffing concerning the child conducted by an authorized agency; and

(G) attend all legal proceedings in the suit.

(b) In addition to the duties required by Subsection (a), an attorney ad litem appointed for a child in a proceeding under Chapter 262 or 263 shall:

(1) review the medical care provided to the child;

(2) in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided; and

(3) for a child at least 16 years of age, advise the child of the child's right to request the court to authorize the child to consent to the child's own medical care under Section 266.010.

SECTION 3. Section 263.306(a), Family Code, is amended to read as follows:

(a) At each permanency hearing the court shall:

(1) identify all persons or parties present at the hearing or those given notice but failing to appear;

(2) review the efforts of the department or another

agency in:

(A) attempting to locate all necessary persons;

(B) requesting service of citation; and

(C) obtaining the assistance of a parent in providing information necessary to locate an absent parent, alleged father, or relative of the child;

(3) review the efforts of each custodial parent, alleged father, or relative of the child before the court in providing information necessary to locate another absent parent, alleged father, or relative of the child;

(4) return the child to the parent or parents if the child's parent or parents are willing and able to provide the child with a safe environment and the return of the child is in the child's best interest;

(5) place the child with a person or entity, other than a parent, entitled to service under Chapter 102 if the person or entity is willing and able to provide the child with a safe environment and the placement of the child is in the child's best interest;

(6) evaluate the department's efforts to identify relatives who could provide the child with a safe environment, if the child is not returned to a parent or another person or entity entitled to service under Chapter 102;

(7) evaluate the parties' compliance with temporary orders and the service plan;

(8) review the medical care provided to the child as required by Section 266.007;

(9) ensure the child has been provided the opportunity, in a developmentally appropriate manner, to express the child's opinion on the medical care provided;

(10) for a child receiving psychotropic medication, determine whether the child:

(A) has been provided appropriate psychosocial therapies, behavior strategies, and other non-pharmacological interventions; and

(B) has been seen by the prescribing physician at least once every 90 days for purposes of the review required by Section 266.011;

(11) determine whether:

(A) the child continues to need substitute care;

(B) the child's current placement is appropriate for meeting the child's needs, including with respect to a child who has been placed outside of the state, whether that placement continues to be in the best interest of the child; and

(C) other plans or services are needed to meet the child's special needs or circumstances;

(12) [~~(9)~~] if the child is placed in institutional care, determine whether efforts have been made to ensure placement of the child in the least restrictive environment consistent with the best interest and special needs of the child;

(13) [~~(10)~~] if the child is 16 years of age or older, order services that are needed to assist the child in making the transition from substitute care to independent living if the services are available in the community;

(14) [~~(11)~~] determine plans, services, and further temporary orders necessary to ensure that a final order is rendered before the date for dismissal of the suit under this chapter;

(15) [~~(12)~~] if the child is committed to the Texas Juvenile Justice Department [~~Youth Commission~~] or released under supervision by the Texas Juvenile Justice Department [~~Youth Commission~~], determine whether the child's needs for treatment, rehabilitation, and education are being met; and

(16) [~~(13)~~] determine the date for dismissal of the suit under this chapter and give notice in open court to all parties of:

(A) the dismissal date;

(B) the date of the next permanency hearing; and

(C) the date the suit is set for trial.

SECTION 4. Section 263.503(a), Family Code, is amended to read as follows:

(a) At each placement review hearing, the court shall determine whether:

(1) the child's current placement is necessary, safe, and appropriate for meeting the child's needs, including with respect to a child placed outside of the state, whether the placement continues to be appropriate and in the best interest of the child;

(2) efforts have been made to ensure placement of the child in the least restrictive environment consistent with the best interest and special needs of the child if the child is placed in institutional care;

(3) the services that are needed to assist a child who is at least 16 years of age in making the transition from substitute care to independent living are available in the community;

(4) the child is receiving appropriate medical care;

(5) the child has been provided the opportunity, in a developmentally appropriate manner, to express the child's opinion on the medical care provided;

(6) a child who is receiving psychotropic medication:

(A) has been provided appropriate psychosocial therapies, behavior strategies, and other non-pharmacological interventions; and

(B) has been seen by the prescribing physician at least once every 90 days for purposes of the review required by Section 266.011;

(7) other plans or services are needed to meet the child's special needs or circumstances;

(8) [~~(5)~~] the department or authorized agency has exercised due diligence in attempting to place the child for adoption if parental rights to the child have been terminated and the child is eligible for adoption;

(9) [~~(6)~~] for a child for whom the department has been named managing conservator in a final order that does not include termination of parental rights, a permanent placement, including appointing a relative as permanent managing conservator or returning the child to a parent, is appropriate for the child;

(10) [~~(7)~~] for a child whose permanency goal is another planned, permanent living arrangement, the department has:

(A) documented a compelling reason why adoption, permanent managing conservatorship with a relative or other suitable individual, or returning the child to a parent is not in the child's best interest; and

(B) identified a family or other caring adult who has made a permanent commitment to the child;

(11) [~~(8)~~] the department or authorized agency has made reasonable efforts to finalize the permanency plan that is in effect for the child; and

(12) [~~(9)~~] if the child is committed to the Texas Juvenile Justice Department [~~Youth Commission~~] or released under supervision by the Texas Juvenile Justice Department [~~Youth Commission~~], the child's needs for treatment, rehabilitation, and education are being met.

SECTION 5. Section 264.121, Family Code, is amended by adding Subsection (g) to read as follows:

(g) For a youth taking prescription medication, the department shall ensure that the youth's transition plan includes provisions to assist the youth in managing the use of the medication and in managing the child's long-term physical and mental health needs after leaving foster care, including provisions that inform the youth about:

(1) the use of the medication;

(2) the resources that are available to assist the youth in managing the use of the medication; and

(3) informed consent and the provision of medical care in accordance with Section 266.010(l).

SECTION 6. Section 266.001, Family Code, is amended by adding Subdivision (6) to read as follows:

(6) "Psychotropic medication" means a medication that is prescribed for the treatment of symptoms of psychosis or another mental, emotional, or behavioral disorder and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state. The term includes the following categories when used as described by this subdivision:

(A) psychomotor stimulants;

(B) antidepressants;

(C) antipsychotics or neuroleptics;

(D) agents for control of mania or depression;

(E) antianxiety agents; and

(F) sedatives, hypnotics, or other sleep-promoting medications.

SECTION 7. Section 266.004, Family Code, is amended by adding Subsections (h-1) and (h-2) to read as follows:

(h-1) The training required by Subsection (h) must include training related to informed consent for the administration of psychotropic medication and the appropriate use of psychosocial therapies, behavior strategies, and other non-pharmacological interventions that should be considered before or concurrently with the administration of psychotropic medications.

(h-2) Each person required to complete a training program under Subsection (h) must acknowledge in writing that the person:

(1) has received the training described by Subsection

(h-1);

(2) understands the principles of informed consent for the administration of psychotropic medication; and

(3) understands that non-pharmacological interventions should be considered and discussed with the prescribing physician before consenting to the use of a psychotropic medication.

SECTION 8. Chapter 266, Family Code, is amended by adding Section 266.0042 to read as follows:

Sec. 266.0042. CONSENT FOR PSYCHOTROPIC MEDICATION. (a) Consent to the administration of a psychotropic medication is valid only if:

(1) the consent is given voluntarily and without undue influence; and

(2) the person authorized by law to consent for the foster child receives verbally or in writing information that describes:

(A) the specific condition to be treated;

(B) the beneficial effects on that condition expected from the medication;

(C) the probable health and mental health consequences of not consenting to the medication;

(D) the probable clinically significant side effects and risks associated with the medication; and

(E) the generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reasons the physician recommends the

proposed course of treatment.

(b) Consent to the administration of a psychotropic medication must be evidenced by the completion of a form prescribed by the department that is signed by the person authorized to consent to medical care for the foster child and by the health care provider administering the psychotropic medication or a person designated by that health care provider.

(c) The completed form must be filed in the child's case file and in the child's medical records.

SECTION 9. The heading to Section 266.005, Family Code, is amended to read as follows:

Sec. 266.005. PARENTAL NOTIFICATION OF CERTAIN [~~SIGNIFICANT~~] MEDICAL CONDITIONS.

SECTION 10. Section 266.005, Family Code, is amended by adding Subsection (b-1) and amending Subsection (c) to read as follows:

(b-1) The department shall notify the child's parents of the initial prescription of a psychotropic medication to a foster child and of any change in dosage of the psychotropic medication at the first scheduled meeting between the parents and the child's caseworker after the date the psychotropic medication is prescribed or the dosage is changed.

(c) The department is not required to provide notice under Subsection (b) or (b-1) to a parent who:

(1) has failed to give the department current contact information and cannot be located;

(2) has executed an affidavit of relinquishment of

parental rights;

(3) has had the parent's parental rights terminated; or

(4) has had access to medical information otherwise restricted by the court.

SECTION 11. Section 266.007(a), Family Code, is amended to read as follows:

(a) At each hearing under Chapter 263, or more frequently if ordered by the court, the court shall review a summary of the medical care provided to the foster child since the last hearing. The summary must include information regarding:

(1) the nature of any emergency medical care provided to the child and the circumstances necessitating emergency medical care, including any injury or acute illness suffered by the child;

(2) all medical and mental health treatment that the child is receiving and the child's progress with the treatment;

(3) any medication prescribed for the child, [~~and~~] the condition, diagnosis, and symptoms for which the medication was prescribed, and the child's progress with the medication;

(4) for a child receiving a psychotropic medication:

(A) any psychosocial therapies, behavior strategies, or other non-pharmacological interventions that have been provided to the child; and

(B) the dates since the previous hearing of any office visits the child had with the prescribing physician as required by Section 266.011;

(5) the degree to which the child or foster care

provider has complied or failed to comply with any plan of medical treatment for the child;

(6) [~~(5)~~] any adverse reaction to or side effects of any medical treatment provided to the child;

(7) [~~(6)~~] any specific medical condition of the child that has been diagnosed or for which tests are being conducted to make a diagnosis;

(8) [~~(7)~~] any activity that the child should avoid or should engage in that might affect the effectiveness of the treatment, including physical activities, other medications, and diet; and

(9) [~~(8)~~] other information required by department rule or by the court.

SECTION 12. Chapter 266, Family Code, is amended by adding Section 266.011 to read as follows:

Sec. 266.011. MONITORING USE OF PSYCHOTROPIC DRUG. The person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication shall ensure that the child has an office visit with the prescribing physician at least once every 90 days to allow the physician to:

(1) appropriately monitor the side effects of the medication; and

(2) determine whether:

(A) the medication is helping the child achieve the physician's treatment goals; and

(B) continued use of the medication is appropriate.

SECTION 13. Section 533.0161(b), Government Code, is amended to read as follows:

(b) The commission shall implement a system under which the commission will use Medicaid prescription drug data to monitor the prescribing of psychotropic drugs for [~~children who are~~]:

(1) children who are in the conservatorship of the Department of Family and Protective Services[~~,~~] and

[~~(2)~~] enrolled in the STAR Health Medicaid managed care program or eligible for both Medicaid and Medicare; and

(2) children who are under the supervision of the Department of Family and Protective Services through an agreement under the Interstate Compact on the Placement of Children under Subchapter B, Chapter 162, Family Code.

SECTION 14. The heading to Subchapter A, Chapter 266, Family Code, is repealed.

SECTION 15. The changes in law made by this Act apply to a suit affecting the parent-child relationship pending in a trial court on or filed on or after the effective date of this Act.

SECTION 16. This Act takes effect September 1, 2013.

ADOPTED

MAY 15 2013

Secretary of the Senate

By: Kolkhorst / Nelson H.B. No. 915

Substitute the following for H.B. No. 915:

By: Jane Nelson C.S. H.B. No. 915

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(b-1) In addition to the duties required by Subsection (b), a guardian ad litem appointed for a child in a proceeding under Chapter 262 or 263 shall:

(1) review the medical care provided to the child; and

(2) in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided.

SECTION 2. Section 107.003, Family Code, is amended to read as follows:

Sec. 107.003. POWERS AND DUTIES OF ATTORNEY AD LITEM FOR CHILD AND AMICUS ATTORNEY. (a) An attorney ad litem appointed to represent a child or an amicus attorney appointed to assist the court:

(1) shall:

(A) subject to Rules 4.02, 4.03, and 4.04, Texas Disciplinary Rules of Professional Conduct, and within a reasonable time after the appointment, interview:

(i) the child in a developmentally appropriate manner, if the child is four years of age or older;

(ii) each person who has significant knowledge of the child's history and condition, including any foster parent of the child; and

(iii) the parties to the suit;

(B) seek to elicit in a developmentally appropriate manner the child's expressed objectives of representation;

(C) consider the impact on the child in formulating the attorney's presentation of the child's expressed objectives of representation to the court;

(D) investigate the facts of the case to the extent the attorney considers appropriate;

(E) obtain and review copies of relevant records relating to the child as provided by Section 107.006;

(F) participate in the conduct of the litigation to the same extent as an attorney for a party;

(G) take any action consistent with the child's interests that the attorney considers necessary to expedite the proceedings;

(H) encourage settlement and the use of alternative forms of dispute resolution; and

(I) review and sign, or decline to sign, a proposed or agreed order affecting the child;

(2) must be trained in child advocacy or have experience determined by the court to be equivalent to that training; and

(3) is entitled to:

(A) request clarification from the court if the role of the attorney is ambiguous;

(B) request a hearing or trial on the merits;

(C) consent or refuse to consent to an interview of the child by another attorney;

(D) receive a copy of each pleading or other paper filed with the court;

(E) receive notice of each hearing in the suit;

(F) participate in any case staffing concerning the child conducted by an authorized agency; and

(G) attend all legal proceedings in the suit.

(b) In addition to the duties required by Subsection (a), an attorney ad litem appointed for a child in a proceeding under Chapter 262 or 263 shall:

(1) review the medical care provided to the child;

(2) in a developmentally appropriate manner, seek to elicit the child's opinion on the medical care provided; and

(3) for a child at least 16 years of age, advise the child of the child's right to request the court to authorize the child to consent to the child's own medical care under Section 266.010.

SECTION 3. Section 263.001, Family Code, is amended by amending Subdivision (1) and adding Subdivisions (1-a) and (3-a) to read as follows:

(1) "Advanced practice nurse" has the meaning assigned by Section 157.051, Occupations Code.

(1-a) "Department" means the Department of Family and

Protective Services.

(3-a) "Physician assistant" has the meaning assigned by Section 157.051, Occupations Code.

SECTION 4. Section 263.306(a), Family Code, is amended to read as follows:

(a) At each permanency hearing the court shall:

(1) identify all persons or parties present at the hearing or those given notice but failing to appear;

(2) review the efforts of the department or another agency in:

(A) attempting to locate all necessary persons;

(B) requesting service of citation; and

(C) obtaining the assistance of a parent in providing information necessary to locate an absent parent, alleged father, or relative of the child;

(3) review the efforts of each custodial parent, alleged father, or relative of the child before the court in providing information necessary to locate another absent parent, alleged father, or relative of the child;

(4) return the child to the parent or parents if the child's parent or parents are willing and able to provide the child with a safe environment and the return of the child is in the child's best interest;

(5) place the child with a person or entity, other than a parent, entitled to service under Chapter 102 if the person or entity is willing and able to provide the child with a safe environment and the placement of the child is in the child's best

interest;

(6) evaluate the department's efforts to identify relatives who could provide the child with a safe environment, if the child is not returned to a parent or another person or entity entitled to service under Chapter 102;

(7) evaluate the parties' compliance with temporary orders and the service plan;

(8) review the medical care provided to the child as required by Section 266.007;

(9) ensure the child has been provided the opportunity, in a developmentally appropriate manner, to express the child's opinion on the medical care provided;

(10) for a child receiving psychotropic medication, determine whether the child:

(A) has been provided appropriate psychosocial therapies, behavior strategies, and other non-pharmacological interventions; and

(B) has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days for purposes of the review required by Section 266.011;

(11) determine whether:

(A) the child continues to need substitute care;

(B) the child's current placement is appropriate for meeting the child's needs, including with respect to a child who has been placed outside of the state, whether that placement continues to be in the best interest of the child; and

(C) other plans or services are needed to meet

the child's special needs or circumstances;

(12) [~~(9)~~] if the child is placed in institutional care, determine whether efforts have been made to ensure placement of the child in the least restrictive environment consistent with the best interest and special needs of the child;

(13) [~~(10)~~] if the child is 16 years of age or older, order services that are needed to assist the child in making the transition from substitute care to independent living if the services are available in the community;

(14) [~~(11)~~] determine plans, services, and further temporary orders necessary to ensure that a final order is rendered before the date for dismissal of the suit under this chapter;

(15) [~~(12)~~] if the child is committed to the Texas Juvenile Justice Department [~~Youth Commission~~] or released under supervision by the Texas Juvenile Justice Department [~~Youth Commission~~], determine whether the child's needs for treatment, rehabilitation, and education are being met; and

(16) [~~(13)~~] determine the date for dismissal of the suit under this chapter and give notice in open court to all parties of:

(A) the dismissal date;

(B) the date of the next permanency hearing; and

(C) the date the suit is set for trial.

SECTION 5. Section 263.503(a), Family Code, is amended to read as follows:

(a) At each placement review hearing, the court shall determine whether:

(1) the child's current placement is necessary, safe, and appropriate for meeting the child's needs, including with respect to a child placed outside of the state, whether the placement continues to be appropriate and in the best interest of the child;

(2) efforts have been made to ensure placement of the child in the least restrictive environment consistent with the best interest and special needs of the child if the child is placed in institutional care;

(3) the services that are needed to assist a child who is at least 16 years of age in making the transition from substitute care to independent living are available in the community;

(4) the child is receiving appropriate medical care;

(5) the child has been provided the opportunity, in a developmentally appropriate manner, to express the child's opinion on the medical care provided;

(6) a child who is receiving psychotropic medication:

(A) has been provided appropriate psychosocial therapies, behavior strategies, and other non-pharmacological interventions; and

(B) has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days for purposes of the review required by Section 266.011;

(7) other plans or services are needed to meet the child's special needs or circumstances;

(8) [~~(5)~~] the department or authorized agency has exercised due diligence in attempting to place the child for

adoption if parental rights to the child have been terminated and the child is eligible for adoption;

(9) [~~(6)~~] for a child for whom the department has been named managing conservator in a final order that does not include termination of parental rights, a permanent placement, including appointing a relative as permanent managing conservator or returning the child to a parent, is appropriate for the child;

(10) [~~(7)~~] for a child whose permanency goal is another planned, permanent living arrangement, the department has:

(A) documented a compelling reason why adoption, permanent managing conservatorship with a relative or other suitable individual, or returning the child to a parent is not in the child's best interest; and

(B) identified a family or other caring adult who has made a permanent commitment to the child;

(11) [~~(8)~~] the department or authorized agency has made reasonable efforts to finalize the permanency plan that is in effect for the child; and

(12) [~~(9)~~] if the child is committed to the Texas Juvenile Justice Department [~~Youth Commission~~] or released under supervision by the Texas Juvenile Justice Department [~~Youth Commission~~], the child's needs for treatment, rehabilitation, and education are being met.

SECTION 6. Section 264.121, Family Code, is amended by adding Subsection (g) to read as follows:

(g) For a youth taking prescription medication, the department shall ensure that the youth's transition plan includes

provisions to assist the youth in managing the use of the medication and in managing the child's long-term physical and mental health needs after leaving foster care, including provisions that inform the youth about:

(1) the use of the medication;

(2) the resources that are available to assist the youth in managing the use of the medication; and

(3) informed consent and the provision of medical care in accordance with Section 266.010(1).

SECTION 7. Section 266.001, Family Code, is amended by amending Subdivision (1) and adding Subdivisions (1-a), (6), and (7) to read as follows:

(1) "Advanced practice nurse" has the meaning assigned by Section 157.051, Occupations Code.

(1-a) "Commission" means the Health and Human Services Commission.

(6) "Physician assistant" has the meaning assigned by Section 157.051, Occupations Code.

(7) "Psychotropic medication" means a medication that is prescribed for the treatment of symptoms of psychosis or another mental, emotional, or behavioral disorder and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state. The term includes the following categories when used as described by this subdivision:

(A) psychomotor stimulants;

(B) antidepressants;

(C) antipsychotics or neuroleptics;

(D) agents for control of mania or depression;

(E) antianxiety agents; and

(F) sedatives, hypnotics, or other sleep-promoting medications.

SECTION 8. Section 266.004, Family Code, is amended by adding Subsections (h-1) and (h-2) to read as follows:

(h-1) The training required by Subsection (h) must include training related to informed consent for the administration of psychotropic medication and the appropriate use of psychosocial therapies, behavior strategies, and other non-pharmacological interventions that should be considered before or concurrently with the administration of psychotropic medications.

(h-2) Each person required to complete a training program under Subsection (h) must acknowledge in writing that the person:

(1) has received the training described by Subsection (h-1);

(2) understands the principles of informed consent for the administration of psychotropic medication; and

(3) understands that non-pharmacological interventions should be considered and discussed with the prescribing physician, physician assistant, or advanced practice nurse before consenting to the use of a psychotropic medication.

SECTION 9. Chapter 266, Family Code, is amended by adding Section 266.0042 to read as follows:

Sec. 266.0042. CONSENT FOR PSYCHOTROPIC MEDICATION. Consent to the administration of a psychotropic medication is valid

only if:

(1) the consent is given voluntarily and without undue influence; and

(2) the person authorized by law to consent for the foster child receives verbally or in writing information that describes:

(A) the specific condition to be treated;

(B) the beneficial effects on that condition expected from the medication;

(C) the probable health and mental health consequences of not consenting to the medication;

(D) the probable clinically significant side effects and risks associated with the medication; and

(E) the generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reasons for the proposed course of treatment.

SECTION 10. The heading to Section 266.005, Family Code, is amended to read as follows:

Sec. 266.005. PARENTAL NOTIFICATION OF CERTAIN [~~SIGNIFICANT~~] MEDICAL CONDITIONS.

SECTION 11. Section 266.005, Family Code, is amended by adding Subsection (b-1) and amending Subsection (c) to read as follows:

(b-1) The department shall notify the child's parents of the initial prescription of a psychotropic medication to a foster child and of any change in dosage of the psychotropic medication at the

first scheduled meeting between the parents and the child's caseworker after the date the psychotropic medication is prescribed or the dosage is changed.

(c) The department is not required to provide notice under Subsection (b) or (b-1) to a parent who:

(1) has failed to give the department current contact information and cannot be located;

(2) has executed an affidavit of relinquishment of parental rights;

(3) has had the parent's parental rights terminated; or

(4) has had access to medical information otherwise restricted by the court.

SECTION 12. Section 266.007(a), Family Code, is amended to read as follows:

(a) At each hearing under Chapter 263, or more frequently if ordered by the court, the court shall review a summary of the medical care provided to the foster child since the last hearing. The summary must include information regarding:

(1) the nature of any emergency medical care provided to the child and the circumstances necessitating emergency medical care, including any injury or acute illness suffered by the child;

(2) all medical and mental health treatment that the child is receiving and the child's progress with the treatment;

(3) any medication prescribed for the child, [~~and~~] the condition, diagnosis, and symptoms for which the medication was prescribed, and the child's progress with the medication;

(4) for a child receiving a psychotropic medication:

(A) any psychosocial therapies, behavior strategies, or other non-pharmacological interventions that have been provided to the child; and

(B) the dates since the previous hearing of any office visits the child had with the prescribing physician, physician assistant, or advanced practice nurse as required by Section 266.011;

(5) the degree to which the child or foster care provider has complied or failed to comply with any plan of medical treatment for the child;

(6) [~~(5)~~] any adverse reaction to or side effects of any medical treatment provided to the child;

(7) [~~(6)~~] any specific medical condition of the child that has been diagnosed or for which tests are being conducted to make a diagnosis;

(8) [~~(7)~~] any activity that the child should avoid or should engage in that might affect the effectiveness of the treatment, including physical activities, other medications, and diet; and

(9) [~~(8)~~] other information required by department rule or by the court.

SECTION 13. Chapter 266, Family Code, is amended by adding Section 266.011 to read as follows:

Sec. 266.011. MONITORING USE OF PSYCHOTROPIC DRUG. The person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication shall ensure that the

child has been seen by the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days to allow the physician, physician assistant, or advanced practice nurse to:

(1) appropriately monitor the side effects of the medication; and

(2) determine whether:

(A) the medication is helping the child achieve the treatment goals; and

(B) continued use of the medication is appropriate.

SECTION 14. Section 533.0161(b), Government Code, is amended to read as follows:

(b) The commission shall implement a system under which the commission will use Medicaid prescription drug data to monitor the prescribing of psychotropic drugs for [~~children who are~~]:

(1) children who are in the conservatorship of the Department of Family and Protective Services[~~,~~] and

[~~(2)~~] enrolled in the STAR Health Medicaid managed care program or eligible for both Medicaid and Medicare; and

(2) children who are under the supervision of the Department of Family and Protective Services through an agreement under the Interstate Compact on the Placement of Children under Subchapter B, Chapter 162, Family Code.

SECTION 15. The heading to Subchapter A, Chapter 266, Family Code, is repealed.

SECTION 16. The changes in law made by this Act apply to a

suit affecting the parent-child relationship pending in a trial court on or filed on or after the effective date of this Act.

SECTION 17. This Act takes effect September 1, 2013.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

May 15, 2013

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB915** by Kolkhorst (Relating to the administration and monitoring of health care provided to foster children.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for HB915, As Passed 2nd House: a negative impact of ($961,404) through the biennium ending August 31, 2015.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2014	($461,402)
2015	($500,002)
2016	($486,812)
2017	($486,812)
2018	($486,812)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555
2014	($457,293)	($4,109)	($65,511)
2015	($495,900)	($4,102)	($69,909)
2016	($482,827)	($3,985)	($68,086)
2017	($482,827)	($3,985)	($68,086)
2018	($482,827)	($3,985)	($68,086)

Fiscal Year	Change in Number of State Employees from FY 2013
2014	11.2
2015	13.3
2016	13.3
2017	13.3
2018	13.3

Fiscal Analysis

The bill would amend the Family Code and Government Code as it relates to the administration and monitoring of health care provided to foster children.

The bill would require consent for the administration of a psychotropic medication and it would be valid only if certain conditions are met. The person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication would be required to ensure that the child has been seen at least once every 90 days by the prescribing physician, physician assistant, or advanced practice nurse to: 1) appropriately monitor the side effects of the medication; and 2) determine whether the medication is helping the child achieve the treatment goals and if continued use of the medication is appropriate.

The Department of Family and Protective Services (DFPS) would be required to notify a child's parents of the initial prescription of a psychotropic medication to a foster child and of any changes in the dosage of the psychotropic medication at the first scheduled meeting between the parents and the child's caseworker after the date the psychotropic medication is prescribed.

The bill would require the Health and Human Services Commission (HHSC) to add children eligible for both Medicaid and Medicare and under the supervision of DFPS through an agreement under the Interstate Compact on the Placement of Children to the monitoring of the prescribing of psychotropic drugs.

The changes in law made by the bill would apply to a suit affecting the parent-child relationship pending in a trial court filed on or after the effective date of the bill.

Methodology

In order to provide consent in accordance with the provision of the bill, DFPS has assumed that the medical consenter, provider, and child would all have to be present in a face-to-face health care visit.

DFPS reports that currently 75 percent of caseworkers are unable to do face-to-face appointments and instead participate via phone and/or teleconferencing, and that child protective services (CPS) caseworkers serve as medical consenters for 2,000 children. On average, DFPS reports that each child prescribed psychotropic medication has an estimated 5 visits per year to ensure proper dosage is prescribed. That equates to an additional 625 additional visits per month ((2,000 children X 5 visits X 75%) / 12 months). DFPS assumed that an additional 11 FTEs (human service technicians) would be trained as Medical Consenters and needed in fiscal year 2014 and 13 FTEs in each fiscal year going forward for these face-to-face visits. The Health and Human Services Commission (HHSC) would need 0.2 FTEs in fiscal year 2014 and 0.3 FTEs in fiscal year 2015 and each fiscal year forward for enterprise support services. The estimated cost in All Funds

for these FTEs is $526,914 in fiscal year 2014, $569,911 in fiscal year 2015, and $554,898 in fiscal year 2016 and forward. Presumably not all 2,000 children would be prescribed psychotropic drugs; therefore, costs associated with the provisions of the bill could be less.

It is assumed that any cost associated with modification to the Information Management Protecting Adults and Children in Texas (IMPACT) system, which is the agency's automated casework system, so that data could be provided to HHSC could be accomplished with existing resources.

DFPS does not anticipate any significant fiscal impacts as a result of complying with the other sections of the bill.

Technology

DFPS indicates cost of $10,928 in fiscal year 2014, $12,915 in fiscal year 2015 and going forward in All Funds for additional computer devices and software for the additional FTEs. These costs are included above.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 530 Family and Protective Services, Department of

LBB Staff: UP, SD, CL, MB, SJ, VJC

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

May 9, 2013

TO: Honorable Jane Nelson, Chair, Senate Committee on Health & Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB915** by Kolkhorst (Relating to the administration and monitoring of health care provided to foster children.), **Committee Report 2nd House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for HB915, Committee Report 2nd House, Substituted: a negative impact of ($961,404) through the biennium ending August 31, 2015.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2014	($461,402)
2015	($500,002)
2016	($486,812)
2017	($486,812)
2018	($486,812)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555
2014	($457,293)	($4,109)	($65,511)
2015	($495,900)	($4,102)	($69,909)
2016	($482,827)	($3,985)	($68,086)
2017	($482,827)	($3,985)	($68,086)
2018	($482,827)	($3,985)	($68,086)

Fiscal Year	Change in Number of State Employees from FY 2013
2014	11.2
2015	13.3
2016	13.3
2017	13.3
2018	13.3

Fiscal Analysis

The bill would amend the Family Code and Government Code as it relates to the administration and monitoring of health care provided to foster children.

The bill would require consent for the administration of a psychotropic medication and it would be valid only if certain conditions are met. The person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication would be required to ensure that the child has been seen at least once every 90 days by the prescribing physician, physician assistant, or advanced practice nurse to: 1) appropriately monitor the side effects of the medication; and 2) determine whether the medication is helping the child achieve the treatment goals and if continued use of the medication is appropriate.

The Department of Family and Protective Services (DFPS) would be required to notify a child's parents of the initial prescription of a psychotropic medication to a foster child and of any changes in the dosage of the psychotropic medication at the first scheduled meeting between the parents and the child's caseworker after the date the psychotropic medication is prescribed.

The bill would require the Health and Human Services Commission (HHSC) to add children eligible for both Medicaid and Medicare and under the supervision of DFPS through an agreement under the Interstate Compact on the Placement of Children to the monitoring of the prescribing of psychotropic drugs.

The changes in law made by the bill would apply to a suit affecting the parent-child relationship pending in a trial court filed on or after the effective date of the bill.

Methodology

In order to provide consent in accordance with the provision of the bill, DFPS has assumed that the medical consenter, provider, and child would all have to be present in a face-to-face health care visit.

DFPS reports that currently 75 percent of caseworkers are unable to do face-to-face appointments and instead participate via phone and/or teleconferencing, and that child protective services (CPS) caseworkers serve as medical consenters for 2,000 children. On average, DFPS reports that each child prescribed psychotropic medication has an estimated 5 visits per year to ensure proper dosage is prescribed. That equates to an additional 625 additional visits per month ((2,000 children X 5 visits X 75%) / 12 months). DFPS assumed that an additional 11 FTEs (human service technicians) would be trained as Medical Consenters and needed in fiscal year 2014 and 13 FTEs in each fiscal year going forward for these face-to-face visits. The Health and Human Services Commission (HHSC) would need 0.2 FTEs in fiscal year 2014 and 0.3 FTEs in fiscal year 2015 and each fiscal year forward for enterprise support services. The estimated cost in All Funds

for these FTEs is $526,914 in fiscal year 2014, $569,911 in fiscal year 2015, and $554,898 in fiscal year 2016 and forward. Presumably not all 2,000 children would be prescribed psychotropic drugs; therefore, costs associated with the provisions of the bill could be less.

It is assumed that any cost associated with modification to the Information Management Protecting Adults and Children in Texas (IMPACT) system, which is the agency's automated casework system, so that data could be provided to HHSC could be accomplished with existing resources.

DFPS does not anticipate any significant fiscal impacts as a result of complying with the other sections of the bill.

Technology

DFPS indicates cost of $10,928 in fiscal year 2014, $12,915 in fiscal year 2015 and going forward in All Funds for additional computer devices and software for the additional FTEs. These costs are included above.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 530 Family and Protective Services, Department of

LBB Staff: UP, CL, MB, SJ, VJC

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

April 26, 2013

TO: Honorable Jane Nelson, Chair, Senate Committee on Health & Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB915** by Kolkhorst (Relating to the administration and monitoring of health care provided to foster children.), **As Engrossed**

Estimated Two-year Net Impact to General Revenue Related Funds for HB915, As Engrossed: a negative impact of ($1,148,349) through the biennium ending August 31, 2015.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2014	($567,924)
2015	($580,425)
2016	($567,232)
2017	($567,232)
2018	($567,232)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555
2014	($562,866)	($5,058)	($80,636)
2015	($575,663)	($4,762)	($81,154)
2016	($562,589)	($4,643)	($79,334)
2017	($562,589)	($4,643)	($79,334)
2018	($562,589)	($4,643)	($79,334)

Fiscal Year	Change in Number of State Employees from FY 2013
2014	11.0
2015	13.0
2016	13.0
2017	13.0
2018	13.0

Fiscal Analysis

The bill would amend the Family Code and the Government Code as it relates to the administering and monitoring of health care provided to foster children.

The bill would require consent for the administration of a psychotropic medication. The consent would be valid only if certain conditions are met and the consent must be evidenced by the completion of a form prescribed by the Department of Family and Protective Services (DFPS) that is signed by the person authorized to consent to medical care for the foster child and by the health care provider administering the psychotropic medication or a person designated by that health care provider. The evidence of consent must be filed in the child's case file and in the child's medical record.

The bill would require the person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication to ensure that the child has an office visit with the prescribing physician at least once every 90 days.

The bill would require the Health and Human Services Commission (HHSC) to add children eligible for both Medicaid and Medicare and under the supervision of DFPS through an agreement under the Interstate Compact on the Placement of Children to the monitoring of the prescribing of psychotropic drugs.

Methodology

In order to provide consent in accordance with the provision of the bill, DFPS has assumed that the medical consenter, provider, and child would all have to be present in a face-to-face health care visit.

DFPS reports that currently 75 percent of caseworkers are unable to do face-to-face appointments and instead participate via phone and/or teleconferencing, and that child protective services (CPS) caseworkers serve as medical consenters for 2,000 children. On average, DFPS reports that each child prescribed psychotropic medication has an estimated 5 visits per year to ensure proper dosage is prescribed. That equates to an additional 625 additional visits per month ((2,000 children X 5 visits X 75%) / 12 months). DFPS assumed that an additional 11 human service technicians would be trained as Medical Consenters and needed in fiscal year 2014 and 13 in each fiscal year going forward for these face-to-face visits. The estimated cost for these FTEs is $604,479 in fiscal year 2014, $661,579 in fiscal year 2015, and $646,566 in fiscal year 2016 and forward in All Funds. Presumably not all 2,000 children would be prescribed psychotropic drugs; therefore, costs associated with the provisions of the bill could be less.

DFPS also estimates that there would be a cost to modify the Information Management Protecting Adults and Children in Texas (IMPACT) system, which is the agency's automated casework

system so that data can be provided to HHSC. The agency's estimated cost for this system change is $44,081 (430 hours X $102.51 per hour) in All Funds for fiscal year 2014, bringing the overall cost for fiscal year 2014 to $648,560.

DFPS does not anticipate any significant fiscal impacts as a result of complying with the other sections of the bill.

Technology

DFPS indicates that additional devices and software and changes to IMPACT, at a cost of $55,009 in fiscal year 2014 in All Funds and $12,915 each fiscal year thereafter, would be required. These costs are included above.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 530 Family and Protective Services, Department of

LBB Staff: UP, CL, MB, SJ, VJC

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

April 1, 2013

TO: Honorable Lois W. Kolkhorst, Chair, House Committee on Public Health

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB915** by Kolkhorst (Relating to the administration and monitoring of health care provided to foster children.), **Committee Report 1st House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for HB915, Committee Report 1st House, Substituted: a negative impact of ($1,148,349) through the biennium ending August 31, 2015.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2014	($567,924)
2015	($580,425)
2016	($567,232)
2017	($567,232)
2018	($567,232)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555
2014	($562,866)	($5,058)	($80,636)
2015	($575,663)	($4,762)	($81,154)
2016	($562,589)	($4,643)	($79,334)
2017	($562,589)	($4,643)	($79,334)
2018	($562,589)	($4,643)	($79,334)

Fiscal Year	Change in Number of State Employees from FY 2013
2014	11.0
2015	13.0
2016	13.0
2017	13.0
2018	13.0

Fiscal Analysis

The bill would amend the Family Code and the Government Code as it relates to the administering and monitoring of health care provided to foster children.

The bill would require consent for the administration of a psychotropic medication. The consent would be valid only if certain conditions are met and the consent must be evidenced by the completion of a form prescribed by the Department of Family and Protective Services (DFPS) that is signed by the person authorized to consent to medical care for the foster child and by the health care provider administering the psychotropic medication or a person designated by that health care provider. The evidence of consent must be filed in the child's case file and in the child's medical record.

The bill would require the person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication to ensure that the child has an office visit with the prescribing physician at least once every 90 days.

The bill would require the Health and Human Services Commission (HHSC) to add children eligible for both Medicaid and Medicare and under the supervision of DFPS through an agreement under the Interstate Compact on the Placement of Children to the monitoring of the prescribing of psychotropic drugs.

Methodology

In order to provide consent in accordance with the provision of the bill, DFPS has assumed that the medical consenter, provider, and child would all have to be present in a face-to-face health care visit.

DFPS reports that currently 75 percent of caseworkers are unable to do face-to-face appointments and instead participate via phone and/or teleconferencing, and that child protective services (CPS) caseworkers serve as medical consenters for 2,000 children. On average, DFPS reports that each child prescribed psychotropic medication has an estimated 5 visits per year to ensure proper dosage is prescribed. That equates to an additional 625 additional visits per month ((2,000 children X 5 visits X 75%) / 12 months). DFPS assumed that an additional 11 human service technicians would be trained as Medical Consenters and needed in fiscal year 2014 and 13 in each fiscal year going forward for these face-to-face visits. The estimated cost for these FTEs is $604,479 in fiscal year 2014, $661,579 in fiscal year 2015, and $646,566 in fiscal year 2016 and forward in All Funds. Presumably not all 2,000 children would be prescribed psychotropic drugs; therefore, costs associated with the provisions of the bill could be less.

DFPS also estimates that there would be a cost to modify the Information Management Protecting Adults and Children in Texas (IMPACT) system, which is the agency's automated casework

system so that data can be provided to HHSC. The agency's estimated cost for this system change is $44,081 (430 hours X $102.51 per hour) in All Funds for fiscal year 2014, bringing the overall cost for fiscal year 2014 to $648,560.

DFPS does not anticipate any significant fiscal impacts as a result of complying with the other sections of the bill.

Technology

DFPS indicates that additional devices and software and changes to IMPACT, at a cost of $55,009 in fiscal year 2014 in All Funds and $12,915 each fiscal year thereafter, would be required. These costs are included above.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 530 Family and Protective Services, Department of

LBB Staff: UP, CL, MB, SJ, VJC

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

March 5, 2013

TO: Honorable Lois W. Kolkhorst, Chair, House Committee On Public Health

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB915** by Kolkhorst (Relating to the administration and monitoring of certain medications provided to foster children.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for HB915, As Introduced: a negative impact of ($2,413,462) through the biennium ending August 31, 2015.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2014	($1,277,759)
2015	($1,135,703)
2016	($1,138,466)
2017	($1,141,339)
2018	($1,144,277)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555	Change in Number of State Employees from FY 2013
2014	($1,266,898)	($10,861)	($182,813)	25.0
2015	($1,126,404)	($9,299)	($158,741)	25.0
2016	($1,129,144)	($9,322)	($159,128)	25.0
2017	($1,131,993)	($9,346)	($159,529)	25.0
2018	($1,134,907)	($9,370)	($159,940)	25.0

Fiscal Analysis

The bill would amend the Family Code and Government Code as it relates to the administration and monitoring of certain medication provided to foster children. The bill would make

administration of a psychotropic drug valid only if it is provided in the manner provided by Section 576.025b, Health and Safety Code. It would also allow evidence of consent to be included in the foster child's health passport. The bill would expand the monitoring of the prescriptions of psychotropic drugs to include children under the supervision of the Department of Family and Protective Services (DFPS) through an agreement under the Interstate Compact on the Placement of Children and those who are eligible for both Medicaid and Medicare.

Methodology

In order to provide consent in accordance with the provisions of the bill, DFPS has assumed that the medical consenter, provider, and child would all have to be present in a face-to-face health care visit.

DFPS reports that currently 75 percent of caseworkers are unable to do face-to-face appointments and instead participate via phone call and/or teleconferencing, and that child protective services (CPS) caseworkers serve as a medical consenter for 2,000 children. On average, DFPS reports that each child prescribed psychotropic medications has an estimated 5 visits per year to ensure that the proper dosage is prescribed. It is assumed that each visit would require 3.5 hours (including the visit with the physician, waiting to be seen, and travel to and from the appointment with the child) resulting in the need for an additional 17 CPS caseworkers. Each caseworker would need supporting staff so it is assumed that an additional 8 full-time equivalents would also be needed. The estimated cost for these FTEs is $1,416,491 in FY14, $1,294,445 in FY15, $1,297,594 in FY16, $1,300,867 in FY17, and $1,304,216 in FY18 in All Funds. These costs include salaries, benefits and other related costs. Presumably not all 2,000 children would be prescribed psychotropic drugs; therefore, costs associated with the provisions of the bill could be less.

DFPS also estimates that there would be a cost to modify the Information Management Protecting Adults and Children in Texas (IMPACT) system, which is the agency's automated casework system so that data can be provided to the Health and Human Services Commission. The agency's estimated cost for this system change is $44,081 (430 hours X $102.51 per hour) in All Funds for FY14, bringing the overall cost to $1,460,572 in FY14.

DFPS does not anticipate any significant fiscal impact as a result of complying with the other sections of the bill. The Health and Human Services Commission and the Office of Court Administration do not anticipate any significant fiscal impacts as a result of complying with any of the provisions of the bill.

Technology

DFPS indicates that additional devices and software and changes to the IMPACT system, at a cost of $67,455 in All Funds in FY14 and $23,374 each fiscal year thereafter, would be required. These costs are included above.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 212 Office of Court Administration, Texas Judicial Council, 530 Family and Protective Services, Department of

LBB Staff: UP, CL, MB, SJ, VJC