Historic Roadmap

Connecting children and youth in foster care with a medical home that can meet their special health care needs through promoting the care standards developed by the American Academy of Pediatrics

www.ncpeds.org/fosteringhealthnc
July 2017
Fostering Health NC is led by the North Carolina Pediatric Society and is a partnership among pediatricians from across the state, Community Care of North Carolina and its regional care management networks, and many parts of the North Carolina Department of Health and Human Services (NC DHHS) – Division of Social Services, Office of Rural Health, Division of Medical Assistance and Division of Public Health. Fostering Health NC works to bridge the gap between child welfare and child health care by connecting children in foster care with a medical home that can meet their special health care needs through promoting the standards developed by the American Academy of Pediatrics.

Founded in 1931, the North Carolina Pediatric Society (NCPeds) is the state affiliate Chapter of the American Academy of Pediatrics with 2,000 pediatrician and pediatric health professional members. Its mission is to empower pediatricians and its partners to foster the physical, social, and emotional well-being of infants, children, adolescents and young adults.

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RESEARCH SUPPORT AND BACKGROUND

The Center for Health Care Strategies estimates that the health care costs for the foster care population are three times those of the non-fostered Medicaid population (Allen, Pires, & Mahadevan, 2012) and the foster care population experiences higher rates of physical, dental, and mental health problems than any other group of children (Ringeisen, Casanueva, Urato, & Cross, 2008). Turney and Wildeman (2016) found using a large nationally representative sample that children in foster care are “in poor mental and physical health relative to children in virtually every other type of family situation and in children in economically disadvantaged families” (p. 10). Further, the long-term effects of Adverse Childhood Experiences (ACEs), defined as physical, emotional, sexual abuse; physical or emotional neglect; parental mental illness; substance dependence; incarceration; parental separation/divorce; or domestic violence, have been documented (Felitti et al., 1998). Shonkoff and Garner (2012) discuss the life-long costs of childhood toxic stress and how “the consequences of significant adversity early in life prompt an urgent call for innovative strategies to reduce toxic stress within the context of a coordinated system of policies and services guided by an integrated science of early childhood and early brain development” (p. e243).

Children in foster care have often been exposed to significant trauma and because they tend to move around, they have often had episodic, fragmented and inadequate health care. For all of these reasons, the American Academy of Pediatrics (AAP) and the Child Welfare League of America (CWLA) consider children in foster care to be Children and Youth with Special Health Care Needs (CYSHCN) (American Academy of Pediatrics, 2005). In 2005, the AAP and its partners developed the “Healthy Foster Care America” initiative to bring various disciplines together to develop a collaborative action plan to improve the health and well-being of children in foster care (www.aap.org/fostercare).

According to the American Academy of Pediatrics, children and adolescents in foster care should:

- Be seen early upon entry into foster care
- Be seen often while they are in foster care
- Have an enhanced health care schedule
- Have comprehensive evaluations

Children in foster care need to be seen early and more often to monitor, support, educate and empower children and youth and their foster and biological parents. The AAP and CWLA have published standards for health care for children and youth in foster care which specify the parameters for high-quality health care. These standards are briefly described below and are available in the AAP Standards of Care handout.
found in the Fostering Health NC Online Library and from the AAP website (www.aap.org/en-us/advocacyand-policy/aap-health-initiatives/healthy-foster-careamerica/Pages/Health-Care-Standards.aspx).

Enhanced Schedule of Medical Visits Recommended by the American Academy of Pediatrics

- **Initial Visit** within 72 hours focused on acute care needs
- **Comprehensive Visit** within 30 days of placement
- **Follow-up Well-Visit** within 60-90 days of placement, and continuing based on the child’s age:
  - 0-6 months old: Visits monthly
  - 6-24 months old: Visits every 3 months
  - 2-21 years old: Visits twice per year, or at times of significant change

Fostering Health NC is based on the AAP’s Healthy Foster Care America and has roots within the state going back to 2008 when pediatric champions such as Dr. Marian Earls brought the needs of children in foster care to the forefront. “Fostering Health NC assures that all children and adolescents in foster care receive care with a perspective on the whole child – for general health, oral health, and especially social-emotional health – in the context of family, school, and community. Our cross-sector collaboration is a crucial innovation,” shared Dr. Earls.

Additionally, Fostering Health NC puts into practice North Carolina’s Health Oversight and Coordination Plan (HOCP) (Hagele & Staroneck, 2013). The HOCP is a health services plan for the foster care population required by the federal law, Fostering Connections to Success and Increasing Adoptions Act of 2008. This federal law requires State and Tribal agencies to develop a plan for ongoing oversight and coordination of health care services for children in foster care, including mental health and dental health needs, in coordination with the State Medicaid agency, pediatricians, general practitioners and specialists (for example, obstetrics and gynecology doctors), other health care experts, and child welfare experts (section 422(b)(15) of the Act). North Carolina’s Health Oversight and Coordination Plan for children served by the foster care program, first developed in 2012 by the NC Pediatric Society through a contract with the NC Division of Social Services, meets the requirements of Public Law 110-351, Section 205, the Fostering Connections to Success and Increasing Adoptions Act of 2008; Public Law 111-148, the Patient Protection and Affordable Care Act; and Public Law 112-34, the Child and Family Services Improvement
and Innovation Act. The NC Division of Social Services collaborates with the NC Pediatric Society and Fostering Health NC to help provide oversight and monitoring of the plan.

Fostering Health NC is led by the NC Pediatric Society and is a partnership among pediatricians from across the state, Community Care of North Carolina and its regional care management networks, and many parts of the NC Department of Health and Human Services (NC DHHS) – Division of Social Services, Office of Rural Health, Division of Medical Assistance and Division of Public Health. It works to bridge the gap between child welfare and child health care by connecting children in foster care with a medical home that can meet their special health care needs, and promoting the enhanced care standards developed by the AAP. The AAP Standards of Care for children in foster care, described earlier, include the recommended periodicity schedule and important developmental, social-emotional/mental health, educational, and dental screenings that should occur within 30 days of a child being placed into foster care, as well as the enhanced schedule of ongoing well-visits for these children. According to the current NC Health Check Program Guide, there is no limit on the number of well-child visits since these enhanced visits are medically necessary.

The project leverages strategic partnerships among three key stakeholder groups at the local level (the department of social services, care management network, and medical home) for the approximately 11,000 children in foster care (Duncan et al., 2013). The project model (see Appendix B) calls upon local stakeholders to work together to coordinate and provide trauma-informed care for this exceptionally vulnerable population. The project spreads best practices, provides local implementation support across the state, and is guided by a State Advisory Team comprised of over 50 professionals in child health, mental health, pharmacy, and social services. From 2014-2016 the State Advisory Team met every month, and in 2017 begun meeting bi-monthly, with workgroups meeting during the off months. In addition to developing an online resource library full of best practices (see www.ncpeds.org/fosteringhealthnc), Fostering Health NC has helped establish state level policies that facilitate information sharing at the local level. The strategic collaboration and information sharing among local child welfare agencies, medical homes, Medicaid and other state and local level stakeholders has led to recognition of the program by the AAP’s National Center for Medical Home Implementation as an innovative and promising practice (see https://medicalhomeinfo.aap.org/practices/Pages/Fostering-Health-North-Carolina.aspx). Fostering Health NC is one of only four state-based organizations to be recognized at this level. Further success of the program was validated when the program was written into North Carolina’s proposed Medicaid 1115 waiver for continued implementation statewide. For a summary on Fostering Health NC, see Appendix A.
FOSTERING HEALTH NC: PROGRAM STRATEGY

Fostering Health NC is a systems building project with the goal of improving the overall health and well-being of children in foster care. It utilizes the foster care medical home model (see Appendix B), which is specific to children in foster care and developed by Marian Earls, MD, MTS, FAAP, Director of Pediatric Programs for Community Care of North Carolina. The AAP first introduced the medical home model as an approach to primary care in 1967. There is a significant amount of evidence regarding the positive impact of the medical home model on the quality of care for pediatric populations (Long, Bauchner, Sege, Cabral, & Garg, 2012). Additional studies have shown that the medical home model, coupled with care coordination, improves health care for children in foster care (Jaudes, Champagne, Harden, Masterson, & Bilaver, 2012).

In order to address many of the barriers faced when providing care and services to the foster population, the project engaged state and local leadership. These successful strategic partnerships led to many innovations over the years, and are focused in the following key areas described below:

Training Personnel · Changing Processes · Informing Policy · Leveraging Technology

I. Training Personnel

The Fostering Health NC program is coordinated by staff housed at the NC Pediatric Society (NCPeds) in Raleigh. The core team works closely with Community Care of North Carolina’s (CCNC) regional care management networks which exponentially expands the reach of the program. The Fostering Health NC team is further supported by a few consultants located in strategic areas of the state which allows program staff to travel to counties to deliver trainings, technical assistance, and convene and attend stakeholder meetings as needed. Educational trainings are offered in-person and via WebEx to county DSS staff, medical providers, care managers, regional care management network staff, and public and private child welfare officials. Trainings are conducted in partnership with the local CCNC network. Fostering Health NC staff also provide trainings and technical assistance to other state partners including the Division of Social Services, school nurses, public health, private child placing agencies and residential providers, behavioral health providers, and others as requested.

Trainings cover a variety of topics, including but not limited to:

- The Fostering Health NC program
- Foster care medical home model
• AAP Standards of Care for children in foster care, which includes an enhanced schedule of medical visits, care coordination, and a particular focus on the child’s social-emotional health
• Adverse Childhood Experiences (ACEs) and long-term effects of ACEs
• The impact of trauma on the developing child birth to age five
• Trauma-informed care, and helping children and families cope with trauma
• The medical home serving as a hub for co-managing a child’s care with behavioral health providers and specialists
• Best practices for medication management, particularly psychotropic medications
• Network care management resources available to assist county DSS staff
• Access to Provider Portal, which houses claims data for patients receiving Medicaid

Fostering Connections Self-paced Online Courses
Fostering Health NC worked with the Family and Children's Resource Program, part of the Jordan Institute for Families at the UNC Chapel Hill School of Social Work, to develop two courses and two video segments for child welfare professionals. The courses, which launched in December 2015, are focused on optimizing collaboration among local stakeholders, including the interagency partnerships needed between county Departments of Social Services, medical homes, and regional CCNC networks. The courses can be used to train child welfare professionals from public and private child-placing agencies across the state, and are particularly useful when retraining staff following agency turnover. The courses, described below, are available for continuing education credits via ncswLearn.org, the learning website for North Carolina's human services professionals. Additionally, CCNC has partnered with NCPeds to make these courses publicly available and expand the knowledge base of professionals serving the foster population (see http://bit.ly/2aBtQpB).

**Fostering Connections I: Partnering to Improve the Health and Well-being of Children in Foster Care.** This is a brief course for child welfare line staff, supervisors, managers, and directors aimed at optimizing collaboration between social services, medical homes, and local Community Care Networks.

**Fostering Connections II: Building Local Systems to Improve the Health and Well-being of Children in Foster Care.** This short course is designed to help agency leaders create successful interagency partnerships between Departments of Social Services, medical homes, and local Community Care Networks.
II. Changing Processes

The need to cultivate partnerships at both state and local levels is critical to the success of systems change. In many communities, prior to the start of Fostering Health NC, all three stakeholder groups (department of social services, regional care management network, and medical home) were not working together in a meaningful way around foster care medical homes. The regional care management network and medical homes were already well connected, however prior to Fostering Health NC, local departments of social services grew frustrated when reaching out to assure medical visits for children in foster care. One of the major roles for the Fostering Health NC staff has been in convening local stakeholders at regular community meetings. These meetings are critical to developing relationships for working together towards common goals and allowing the disciplines to better understand one another’s daily world. An excellent example is that prior to the start of Fostering Health NC, barriers existed regarding the language and terminology that was used for scheduling medical visits. Social workers or foster parents would call the medical practice and request a “physical” appointment for a child in foster care. That request for a “physical” would send the medical practice scheduler looking for an hour-long appointment, which are hard to come by in most practices.

By using the AAP Standards of Care for children in foster care, the project quickly addressed this barrier by defining an “Initial Visit” for a child in foster care that is a shorter appointment focused on acute care needs and a “30-day Comprehensive Visit” that occurs within 30 days of the child coming into care and is a longer visit. This language was put into the best practice documents the project developed and disseminated, and has helped ensure that children receive their initial medical assessment within three to seven days upon entering foster care. In fact, as the Fostering Health NC model calls for (see Appendix B), medical homes utilize “sick” or “acute” visits held each week for these “Initial Visits” for children in foster care. Ongoing local stakeholder meetings can focus on mitigating challenges like this one, or on programmatic updates, celebrating success, and talking through specific case issues. As time goes on, the Fostering Health NC team’s convener role lessens within a given community as local stakeholders begin to take the lead.

Fostering Health NC staff provide technical assistance to local stakeholders throughout implementation. The project uses the National Association for the Education of Young Children’s definition of Technical Assistance: “the provision of targeted and customized support by a professional(s) with subject matter and adult learning knowledge and skill to develop and strengthen processes, knowledge application, or implementation of service by recipients” (Young, 2012, p. 6). Technical assistance includes activities where the expert assists stakeholders in a targeted way by providing advice and hands-on support to a complex or unfamiliar task (Centers for Medicare and Medicaid Services Quality Improvement Organizations Program). The goals of technical assistance within this project are to (1) provide individualized information
the helps stakeholders strengthen their use of the Fostering Health NC model to (2) ultimately improve physical and mental health outcomes for children and youth in foster care.

Technical Assistance is provided on a variety of topics, including but not limited to:

- Meeting facilitation and convening of stakeholders
- Discovering barriers to implementation and problem solving
- Developing work flows for medical homes and county DSS agencies focused on clear, consistent communication to ensure smooth implementation of the model
- Using the required NC Division of Social Services Health Summary Forms developed through the program
- Streamlining the language used when calling to make medical appointments for children in foster care
- Executing a Technology-Enabled Care Coordination Agreement (TECCA), which allows county DSS staff to access Medicaid claims data on children in foster care custody
- Using various tools from the extensive Fostering Health NC online library, including the Custody Notification Status Form for notifying providers, the school nurse, and care manager when a child is new to foster care or experiences a change in placement
- Connecting peers across networks/counties/practices who are facing similar challenges and spreading successful solution(s)
- Connecting staff from one stakeholder agency with another, or engaging staff from other local agencies—e.g., including school nurses in collaborative meetings
- Introducing medical providers and county DSS staff to the regional CCNC network pharmacist who can do medication reviews for children in foster care
- Connecting stakeholders to state and local resources

III. Informing Policy

Over the years, barriers to collaboration both at the state and local level have been identified. Fostering Health NC has identified policy recommendations to resolve these long-standing barriers to collaboration. As implementation of the project has progressed, increased attention has been paid to the health care needs of children in foster care. Importantly, this progress has led to a number of policy developments in North Carolina. Some examples include:

- The NC Division of Social Services adopted the Health Summary Forms that the Fostering Health NC project promotes. These forms are required as of April 15, 2016 per NC Division of Social Services Administrative Letter (see the Fostering Health NC Online Library, www.ncpeds.org/fosteringhealthnc). These forms were developed through collaboration
among the Fostering Health NC State Advisory Team members and encourage exchange of information among the physician, care managers, and social services staff (in particular, Health History Form, items II, V, and VI).

• The NC Division of Social Services released a series of Dear County Director Letters (DCDLs) beginning October 2014, and can be found on the Fostering Health NC Online Library. One DCDL supports the Fostering Health NC project; one outlines the legal pathway for county level access to Medicaid claims data; one encourages enrollment for children in foster care with a CCNC physician that is reflected on the child’s Medicaid card upon enrollment into foster care; and one emphasizes appropriate use and monitoring of psychotropic medications including resources from CCNC to aid each child placing agency in these efforts.

• The Best Practices for Medication Management for Children & Adolescents in Foster Care (see http://bit.ly/2gdw1Tf) was developed and updated in October 2015 by Community Care of North Carolina with the assistance of the Medication Management Workgroup of Fostering Health NC. The workgroup was led by Theodore Pikoulas, PharmD, BCPP, former Associate Director of Behavioral Health Pharmacy Programs at CCNC.

• Psychotropic Medications in Children and Adolescents: Guide for Use and Monitoring (see http://bit.ly/2pAcymd) was developed by Community Care of North Carolina with the assistance of the Medication Management Workgroup of Fostering Health NC. This document was authored by Jerry McKee, PharmD, MS, BCPP, Medical Affairs Director of Pharmacy at CCNC and approved by the CCNC Patient Education Committee.

• The NC Division of Social Services Annual Progress and Services Report (APSR) to the US DHHS Administration for Children & Families in June 2015 outlines Fostering Health NC’s program assistance in operationalizing the North Carolina Health Oversight and Coordination Plan.

  o Establishes who can consent to treatment of children/youth in foster care under various circumstances.
  o Codifies physician access to confidential information (see 7B-505.1 (e) and (f)).

After the statute was changed, the Administrative Office of the Courts updated the standard forms judges’ use (AOC-J-150 and AOC-J-151) to order children or youth into DSS custody. These forms reflect the new statute and clarify DSS authority to consent to medical care.
In addition, DSS Form 1812, General Authorization for Treatment and Medication, created February 2016, reflects the new statute and supports the communication between parents and social services and documents consent (http://zeus.dhhs.state.nc.us/olm/forms/dss/dss-1812-ia.pdf)

IV. Leveraging Technology

Fostering Health NC Online Resource Library

Fostering Health NC launched its Online Resource Library in July 2014. The online library serves as the central repository for key documents, best practices, and tools to support statewide implementation of the program. The library continues to grow and currently consists of more than 60 documents within the following categories: AAP Guidance, About Fostering Health NC, About the Child Welfare Population, Agency Endorsements and Correspondence, Best Practices, Billing and Coding, Health Forms, Helpful Links, Local Implementation Resources, Parent/Caregiver Resources, Sharing Information, and the Technology-Enabled Care Coordination Agreement (TECCA).

Staff continue to work with state agency partners and members of the State Advisory Team to vet and develop appropriate resources as topics are identified. Most recent additions include Case Management Across LME/MCO Catchment Areas developed by Catharine Goldsmith, MSW, Children’s Behavioral Health Services Manager, Behavioral Health Section for the NC Division of Medical Assistance, with review and input from the Fostering Health State Advisory Team and The NC Council of Community Programs (see http://bit.ly/2keADt4); updated Foster Care Visit Options and Codes (see http://bit.ly/2jUOQPQ) developed by Marian F Earls, MD, MTS, FAAP, Director of Pediatric Programs for CCNC; the Best Practices for School Nurses vetted by the UNC School of Government and Ann Nichols RN, MSN, NCSN, State School Health Nurse Consultant, Division of Public Health; several parent/caregiver resources, some of which are also available on the NC Division of Social Services learning site for North Carolina foster and adoptive parents and kinship caregivers (http://fosteringnc.org/key-foster-care-and-adoptive-resources/); and Innovative Ideas, developed by the Fostering Health NC Implementation Workgroup (see http://bit.ly/2lZjkNO).

Medicaid Claims Data Made Available to Counties/County DSS Agencies

Fostering Health NC has worked to make existing technology and important patient information available to key project stakeholders. In May 2014, partner agencies (namely, the NC DHHS Privacy Office, NC Division of Medical Assistance, NC Division of Social Services, NC Office of Rural Health, DHHS Assistant Attorney General’s Office, and CCNC) drafted the first Technology-Enabled Care Coordination Agreement (TECCA) for Counties/County DSS agencies. The TECCA provides a legal pathway for Counties/County DSS agencies to access Medicaid claims data on children in DSS custody through the CCNC Informatics
Center Provider Portal. Importantly, this agreement was the first time this opportunity has been made available to child welfare staff.

The Medicaid claims information stored within the CCNC Informatics Center Provider Portal is critical in making care decisions for children in foster care. Some examples of the type of information included in Provider Portal are: primary care provider contact information; care coordination contact information (including care manager, CCNC network, network pharmacist, and mental health LME); medication fill history; recent office, emergency department, inpatient and behavioral health visits; procedures; diagnoses; and immunizations. Additionally, the Provider Portal provides continuity of medical records for children in foster care in the absence of a statewide case management system or Health Passport. CCNC network care managers upload completed Health Summary Forms to the Provider Portal, which assists DSS social workers in knowing the child's health history when children frequently move from county to county. All too often, and for a variety of reasons, DSS social workers do not have reliable health history on children taken into custody. Anecdotally we have heard from many county DSS agencies about the usefulness of Provider Portal, many times in discovering chronic conditions such as asthma that have gone untreated simply because no one knew. Once there is an executed TECCA with a County/County DSS agency, regional CCNC networks assist credentialed county DSS staff with access to and training on Provider Portal to gain this needed information in an efficient manner. Regional networks re-train DSS staff on Provider Portal as needed.

**Fostering Health NC Videos**

To further illustrate how the various parts of the program are implemented, Fostering Health NC uses several short video segments developed in partnership with the NC Foundation for Advanced Health Programs – NC Center of Excellence for Integrated Care while supported by Children’s Health Insurance Program Reauthorization Act (CHIPRA). The videos are useful because they provide testimonials from local stakeholders who have worked with their community partners to strengthen medical homes for children in foster care. The videos provide information about the program “in their own words”. Some of the videos also include education by pediatricians, county DSS social workers, and CCNC network staff about why the collaboration is important and what the benefits to children in foster care having a health care manager. To view the videos, see [www.ncpeds.org/?page=FHNCVideos](http://www.ncpeds.org/?page=FHNCVideos) or the NCPeds YouTube channel, [http://bit.ly/2lB6usY](http://bit.ly/2lB6usY).
Fostering Health NC Milestones

2005
The AAP and its partners develop “Healthy Foster Care America” initiative

2008
Dr. Marian Earls authors “Foster Care White Paper”

OCT | Federal “Fostering Connections” Act becomes law

2008 - 2009
NCPeds leads NC/SC planning meetings to document recommendations for foster care medical home project

2009
New Hanover foster care medical home pilot project launches

2010
Foster care medical home project launches at Guilford Child Health in Greensboro

2011
NCPeds writes the NC Health Oversight & Coordination Plan (HOCP) through contract with NC DSS

2013
CCNC supports foster care medical home project statewide through CHIPRA and names foster care a priority population
2014

NCPeds convenes Fostering Health NC State Advisory Team

MAR | Full funding for Fostering Health NC through CHIPRA for one year; NCPeds hires two full-time staff members

MAY | Partner agencies draft opportunity for Counties/County DSS agencies to access Medicaid claims data on children in DSS custody (via TECCA)

JUL | Fostering Health NC launches online resource library

OCT | NC DSS releases series of Dear County Director Letters (DCDLs) about the statewide foster care medical home project, Fostering Health NC

2015

FEB | The Duke Endowment and NC DHHS fund Fostering Health NC for two years

JUN | NC DSS Annual Progress and Services Report (APSR) due to the US DHHS Administration for Children & Families. The APSR outlines Fostering Health NC's program assistance in operationalizing the NC HCOP

SEPT | Budget Bill requires standard out-of-network agreement for LME/MCOs

OCT | Fostering Health NC poster presentation at the National AAP Conference

DEC | UNC completes “Fostering Connections” online training modules for social workers and administrators and posts to ncswlLearn.org

2016

APR | NC DSS releases Administrative Letter regarding required Health Summary Forms for children in foster care

JUN | Fostering Health NC written into NC’s proposed Medicaid Innovation Waiver that NC DHHS submitted to Centers for Medicare & Medicaid Services (CMS) for approval for continued implementation statewide

OCT | AAP’s National Center for Medical Home Implementation recognizes Fostering Health NC as an innovative and promising practice

2017

JAN | Fostering Health NC training for NC DSS Children’s Program Representatives (CPRs); CPRs engage counties to troubleshoot implementation challenges

MAR | Fostering Health NC presentation at National CWLA Conference

MAR | Fostering Health NC State Advisory Team convenes three new workgroups focused on private child placing agencies and residential programs, transition age youth/ foster care alumni, and mental health
PROGRAM ACCOMPLISHMENTS

Fostering Health NC has positively transformed medical care for nearly one-third of children in foster care in North Carolina by connecting these children to a medical home equipped to meet their special health care needs. To date, over 100 medical homes and 60 (of 100) county Departments of Social Services (DSS) agencies are trained and equipped with tools and resources to better coordinate care for children in foster care. The Fostering Health NC team works with all 14 of Community Care of North Carolina (CCNC) regional care management networks to convene, educate, and train stakeholders on foster care medical homes.

Research shows coordinating medical care, including mental health, for children in foster care leads to improved health outcomes, higher immunization rates and higher utilization rates for primary care and well-child visits (Jaudes, Champagne, Harden, Masterson, & Bilaver, 2012). Since 2014, the foster population in North Carolina has seen:

<table>
<thead>
<tr>
<th>Increased compliance rates for well-visits for 3-6 year olds, 7-11 year olds, and 12-21 year olds in foster care.</th>
<th>Increased annual dental visits for all ages in foster care 2-20 years old and higher rates for annual dental visits than the Medicaid or NC Health Choice population not in foster care under 21 years of age.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increased rates</strong> for behavioral/developmental screening for children in foster care ages 0-66 months.</td>
<td><strong>Increased rates</strong> for adolescent immunizations, including HPV for females in foster care.</td>
</tr>
</tbody>
</table>
Implementation of the Fostering Health NC Model

The map below shows the various degrees of program implementation across the state. The bright blue areas of the map indicate counties that have all three key stakeholders (county DSS, regional CCNC network, and at least one medical practice) working to implement the project model. The counties in green stripe indicate where the county DSS and regional CCNC network are working together. Some of these counties actually have many medical homes that see children in foster care, though the process to on-board all of those practices is lengthy, and thus those practices will be counted once they become part of ongoing community meetings with the other stakeholder agencies in full effort to implement the model. The few counties that are in darker green indicate where the regional CCNC network and at least one medical practice are working together to implement the model. In some of these counties, like Onslow, the NC DSS Children’s Program Representative staff (CPRs) have begun to work with Fostering Health NC staff to identify and troubleshoot the barriers these county DSS agencies experience that have prevented them from signing on to the program. Finally, the light gray areas of the map indicate counties that have not yet begun implementation. Many of these counties are in rural areas (northeast and far west) where access to medical care is an issue. The Fostering Health NC team is currently working with both regional CCNC networks in these more rural areas and anticipate some of those counties will sign on, with continued support.

The Fostering Health NC program has been very successful, due to many factors. The project’s foundation is built upon the best practice recommendations set by the AAP for the vulnerable population of children in foster care, and the program AAP and its partners developed, Healthy Foster Care America (www.aap.org/fostercare). Many child advocates across the state have worked for at least a decade on
these issues prior to the 2014 launch of Fostering Health NC. The involvement and expertise of the State Advisory Team has been critical to setting the vision and path for the project and in developing strategy and resources. Local collaboration with regional CCNC networks has exponentially expanded the reach of the program. Also having dedicated staff housed at the NC Pediatric Society has allowed for faster implementation of the program, development of resources, and policy changes.

The Fostering Health NC State Advisory Team continues to be critical to the success of Fostering Health NC and recently identified three new workgroups that began convening in March 2017:

1. Child Placing Agencies and Residential Programs
2. Transition Age Youth and Foster Care Alumni, and
3. Mental Health (which includes psychotropic medication management)

Each workgroup is meeting on a regular basis and has researched their area and identified barriers to address. In the June State Advisory Team meeting each workgroup shared and discussed their work thus far, as well as their goals and potential next steps. The output of these workgroups will be incorporated into program implementation and available to the public via the Fostering Health NC online resource library, www.ncpeds.org/fosteringhealthnc.
Fostering Health NC has roots within North Carolina going back to 2008 when pediatric champions like Dr. Marian Earls brought the needs of children in foster care to the forefront through authoring “Foster Care White Paper”, and the North Carolina Pediatric Society (NCPeds) began convening state partners to work on improving health and well-being outcomes for children in foster care. The Fostering Health NC State Advisory Team has met since 2009 and has been critical to the success of the program. For several years the team met every month, and is now meeting bi-monthly. The team consists of over 50 professionals in child health, mental health, pharmacy, and social services who provide expertise and best practice guidance on the many issues and barriers in doing this work. Special thanks to Dr. Gerri Mattson who has provided guidance and leadership, and connected program staff to experts and resources throughout the project. Special thanks to Dr. Jean Smith who serves on the State Advisory Team and as a consultant to the project, presenting to provider and social service groups across the state. The full list of State Advisory Team members can be found on the Fostering Health NC online library.

Through the years, support for the project has come from federal and state sources including The Children’s Health Insurance Program – Reauthorization Act (CHIPRA) and the North Carolina Department of Health and Human Services, as well as private donors including The Duke Endowment, The Eshelman Foundation, and Kate B. Reynolds Charitable Trust. Successful foster care medical home projects in Guilford, New Hanover, and Wake counties laid the foundation for Fostering Health NC, which launched with funding in March 2014 with the hiring of two full-time staff members. From February 2015 – March 2017, the project was supported by joint funding from The Duke Endowment and the NC Department of Health and Human Services, with the Office of Rural Health providing contract management. Beginning in April 2017, the NC Department of Health and Human Services Division of Social Services began supporting the project.

In addition to the above individuals and organizations, Fostering Health NC staff contributed to development and implementation of the program. Adam Svolto served as policy and program director from 2014–2016 and chaired the State Advisory Team. Susan Foosness served as program director from 2016–2017 and chaired the State Advisory Team. Leigh Poole Lodder served as implementation and evaluation manager from 2014–2017 and oversaw program implementation, training, and evaluation reporting. Brooke Jordan served as implementation coordinator providing technical assistance and training from 2015–2017. Leslie Starzoneck launched the program at the NC Pediatric Society in 2014 and later served as a project consultant. Project staff appreciate the support of Elizabeth Hudgins, NCPeds Executive Director, former NCPeds Executive Director, Steve Shore, and past and current NCPeds Board of Directors and members who tirelessly advocate for children across the state.
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APPENDIX A: FOSTERING HEALTH NC PROGRAM SUMMARY AND FLYER
(see next page)
Fostering Health NC Bridges the Gap between Child Welfare and Child Health Care

Over the past two years Fostering Health NC has positively transformed medical care for nearly one-third of children in foster care in North Carolina by connecting these children to a medical home equipped to meet their special health care needs. Fostering Health NC, a project of the North Carolina Pediatric Society (NCPeds), promotes the American Academy of Pediatrics’ (AAP) care standards for children and youth in foster care in order to improve their health and well-being.

Fostering Health NC has roots within the state going back to 2008 when pediatric champions such as Dr. Marian Earls brought the needs of children in foster care to the forefront. “Fostering Health NC assures that all children and adolescents in foster care receive care with a perspective on the whole child – for general health, oral health and especially social-emotional health – in the context of family, school and community. Our cross-sector collaboration is a crucial innovation,” shared Dr. Earls. The project, which launched with full funding in 2014, is a partnership among pediatricians from across the state, Community Care of North Carolina and its regional care management networks, and many parts of the NC Department of Health and Human Services (NC DHHS) – Division of Social Services, Office of Rural Health, Division of Medical Assistance and Division of Public Health.

The project leverages partnerships among key stakeholder groups at the local level that work together to coordinate and provide trauma-informed care for this exceptionally vulnerable population. The project spreads best practices, provides local implementation support across the state and is guided by a 50-member State Advisory Team comprised of professionals in child health, mental health, pharmacy and social services. To date, over 100 medical homes and 60 (of 100) county Departments of Social Services (DSS) agencies are trained and equipped with tools and resources to better coordinate care for children in foster care.

Research shows coordinating medical care, including mental health, for children in foster care leads to improved health outcomes, higher immunization rates and higher utilization rates for primary care and well-child visits. Since 2014, the foster population in North Carolina has seen increased compliance rates for well-visits for 3-6 year olds, 7-11 year olds and 12-21 year olds; increased rates for adolescent immunizations, including HPV for females; increased rates for behavioral/developmental screening for children in foster care ages 0-66 months; increased annual dental visits for all ages in foster care 2-20 years old; and higher rates for annual dental visits than the Medicaid or NC Health Choice population under 21 years of age.

In addition to developing an online resource library full of best practices (see www.ncpeds.org/fosteringhealthnc), Fostering Health NC has helped establish state level
policies that facilitate information sharing at the local level. The strategic collaboration and information sharing among local child welfare agencies, medical homes, Medicaid and other state and local level stakeholders has led to recognition of the program by the AAP's National Center for Medical Home Implementation as an innovative and promising practice. Fostering Health NC is one of only four state-based organizations to have a program recognized at this level. The program was written into North Carolina's proposed Medicaid innovation waiver for continued implementation statewide. Local stakeholders across the state say Fostering Health NC ensures this vulnerable population receives needed services and that all of the disciplines are talking to one another.

The project is supported through March 2017 by joint funding from The Duke Endowment and NC DHHS. With future funding the project could continue to spread best practice and encourage more collaboration between health care and mental health providers around managing medications for the foster population. It would also seek to expand into other areas of focus, including working on issues impacting youth as they transition out of foster care, working more with private licensed family foster homes and residential homes, and working with the Division of Health Benefits to plan and implement changes impacting the foster care population in the proposed Medicaid innovation waiver.

ABOUT THE NORTH CAROLINA PEDIATRIC SOCIETY

Founded in 1931, the North Carolina Pediatric Society (NCPeds) is the state affiliate Chapter of the American Academy of Pediatrics with nearly 2,000 pediatrician and pediatric health professional members. Its mission is to empower pediatricians and its partners to foster the physical, social, and emotional well-being of infants, children, adolescents and young adults.
Connecting children & youth in foster care with a medical home that can meet their special health care needs through promoting the care standards developed by the American Academy of Pediatrics.

Research shows that coordinating medical care, including mental health, for children and youth in foster care leads to improved health outcomes, higher immunization rates, and higher utilization rates for primary care and well-child visits.

Fostering Health NC bridges the gap between child welfare and child health care and leverages strategic partnerships among three key stakeholder groups working to improve the health & well-being of NC’s foster population.

Since 2014

29% of NC's foster care population tied to a medical home implementing the Foster Care Medical Home Model

106 Medical Practices

60 County DSS Child Welfare Agencies

All 14 Community Care NC Regional Care Management Networks

Increased compliance rates for well-visits for 3-6 year olds, 7-11 year olds, and 12-21 year olds in foster care.

Increased rates for behavioral/developmental screening for children in foster care ages 0-66 months.

Increased rates for adolescent immunizations, including HPV for females in foster care.

Increased annual dental visits for all ages in foster care 2-20 years old and higher rates for annual dental visits than the Medicaid or NC Health Choice population not in foster care under 21 years of age.

Written into NC’s proposed Medicaid Innovation Waiver for continued implementation statewide.

Local stakeholders statewide say Fostering Health NC ensures that this vulnerable population receives needed services and that all of the disciplines are talking to one another.

One of four state-based organizations to be recognized as an innovative and promising practice by the AAP’s National Center for Medical Home Implementation.
Fostering Health NC is a project of the NC Pediatric Society and partnership among NC DHHS – Division of Social Services, Office of Rural Health, Division of Medical Assistance, Division of Public Health, Community Care of North Carolina and its regional care management networks, pediatricians from across the state, and The Duke Endowment. Fostering Health NC is supported through March 2017 by joint funding from The Duke Endowment and the North Carolina Department of Health and Human Services.

Learn more at www.ncpeds.org/fosteringhealthnc

Susie was referred by local DSS when she was taken into custody. She was new to foster care and there was very little medical history known about her. I was able to look in Provider Portal at her claims history and find that Susie had asthma, although the DSS social worker and foster parent didn’t know this and had no medication for her. I was able to link her with a provider for her foster care Initial Visit and request that she be assessed for asthma due to claims history. At the visit, Susie was provided with asthma medication and an asthma action plan. Not only was I able to make sure that Susie has what she needs in case of an asthma exacerbation at home or school, but I was also able to provide education to the foster parent to hopefully reduce asthma triggers and help the foster parent feel more confident in caring for a child in foster care with asthma.

— NETWORK NURSE CARE MANAGER

Marco came into custody at the age of 6 due to chronic homelessness. Marco had a diagnosis of autism and needed a foster family that could be educated on his care and ready to be engaged in his needs. We were able to keep this child in his primary care medical home that he had been to most of his life. Upon entering the office for his Initial Visit, Marco was so excited to show us his picture that hung on the wall. The office staff and primary care physician knew him well which put Marco at ease. The doctor was able to go through things with the foster parent to help her understand and be ready to care for him. Marco thrived in this foster home and continued to be well cared for by the primary care physician. He has since been adopted by this foster family though also keeps in contact with his biological mother.

— NURSING SUPERVISOR, MECKLENBURG COUNTY YOUTH & FAMILY SERVICES

A child in foster care needed assistance with medication refills for complex medical needs. We were unable to acquire the medications without assistance from the Network Pharmacist as the prescription required an override. This collaboration helped us understand the child’s ongoing needs for care and ensure there were no gaps in obtaining medications. Without the Network Pharmacist’s assistance, this child would have been without needed medications.

— CHILDREN’S HEALTH & DEVELOPMENT PROGRAM MEDICAL DIRECTOR, WAKE COUNTY HUMAN SERVICES
APPENDIX B: FOSTERING HEALTH NC FOSTER CARE MEDICAL HOME MODEL
(see next page)
### Core Components of a Foster Care Medical Home for Children & Youth in Foster Care

<table>
<thead>
<tr>
<th>Designate foster care contact(s) who receives information on new/changing foster care placement; communicates with Network and DSS contacts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designate scheduler(s).</td>
</tr>
<tr>
<td>Standard # of &quot;acute&quot; visits/week held to accommodate initial foster care visits.</td>
</tr>
<tr>
<td>Schedule Comprehensive foster care visit to occur within 30 days of the child entering foster care (or sooner if medically necessary).</td>
</tr>
<tr>
<td>To prepare for Comprehensive visit: Identify and initiate ROIs for needed records. PCP reviews records prior to the Comprehensive visit. Include biologic parent(s) if appropriate.</td>
</tr>
<tr>
<td>Adopt AAP schedule for Follow-up Well-Visits, incorporating priorities of social-emotional development screening for Children and Youth with Special Health Care Needs (CYSHCN).</td>
</tr>
</tbody>
</table>

### Designate foster care contacts
- Network Care Manager, CC4C Care Manager, Behavioral Health Coordinator, Pharmacist, Psychiatrist, Health Check Coordinator.

### Arrange Informatics Center (IC) Provider Portal access for DSS designee.

### Assure internetwork communication if child is placed out of network (Medical Home PCP to Medical Home PCP, and Care Manager to Care Manager).

### Assure health information from Informatics Center (IC) Provider Portal is shared with PCP, DSS, and foster and biologic parent (if reunification is planned).

### CC4C works with foster family and biologic family (if reunification is planned).

### Assure child/youth in foster care is enrolled in a CCNC Network practice.

### Designate staff for communication with Medical Home and Network who notifies when there is a new/changing placement; shares removal and placement history with Medical Home.

### Designate staff to use Informatics Center (IC) Provider Portal for background on each child entering foster care.

### Standardize process for foster parent/DSS staff to schedule Initial foster care visit.

### Establish a preauthorization process for ROI for Medical Homes.

### Gather medical history and age-appropriate developmental and behavioral screen from biologic parent for Comprehensive visit.

### Refer all 0-5 year olds to CC4C upon entry into custody.
### Core Components of a Foster Care Medical Home for Children & Youth in Foster Care

<table>
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<th>Practice</th>
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<tr>
<td>To prepare for Comprehensive visit: Identify and initiate ROIs for needed records</td>
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</tr>
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Content developed by Marian F Earls, MD, MTS, FAAP, Director of Pediatric Programs for Community Care of North Carolina (CCNC) 8.7.15