Fostering Health NC · Best Practices for CCNC & CC4C

Building and Strengthening Medical Homes for Infants, Children, Adolescents and Young Adults in Foster Care

What is Fostering Health NC? There are approximately 9,000 children in foster care in North Carolina. These children have special health care needs. Often because of the circumstances that led them to be placed into foster care, their physical, developmental, mental/social-emotional and oral health care has been inconsistent and sometimes impacted by crisis or injury. Fostering Health NC, a project of the North Carolina Pediatric Society, is focused on building and strengthening medical homes for infants, children, adolescents and young adults in foster care through integrated communications and coordination of care through a unique partnership among local Departments of Social Services, CCNC Networks, the pediatric care team, the child and the child's family.

A. Facilitating Information Flow

Children entering foster care are in the custody of the local county Department of Social Services (DSS). DSS is responsible for collecting medical history about these children and sharing it with a primary care provider. The vast majority of children in foster care are eligible for Medicaid. Because of this, care managers (CCNC Network care managers and local health department CC4C care managers) are uniquely positioned to facilitate information flow between DSS staff and care providers.

Many children in foster care have had intermittent health care, making CCNC's Provider Portal a critical resource for filling information gaps and identifying problems early. To fully leverage its benefit, care managers should encourage their county partners to sign a Technology-Enabled Care Coordination Agreement (TECCA). Care managers can also accelerate information flow by working with their DSS counterparts to set up secure messaging. [Instructions available in the Fostering Health NC Online Library: http://www.ncpeds.org/foster-care-medical-home]

Care managers should encourage DSS to establish a standard local protocol for notifying the medical home of changes in a child's custody status. [See *Custody Status Notification Template* available in the Fostering Health NC Online Library] Care mangers should also engage practices in identifying patients who are already in foster care.

B. Frequency of Foster Care Visits

Children in foster care need to be seen early and often. Standards published by the American Academy of Pediatrics (AAP) and Child Welfare League of America (CWLA) are available in the Fostering Health NC Online Library or the AAP website. [See http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx].

Summary of the AAP Standards:

- **0-6 months of age:** Should be seen every month
- **6-24 months of age:** Should be seen every 3 months
- **2-21 years and times of significant change:** Should be seen every 6 months

C. Types of Foster Care Visits

According to the AAP Standards of Care, an ***Initial Visit*** should occur within 72 hours of placement into foster care (NC Division of Social Services standard for completing this visit is within seven days). The *Initial Visit* should be an assessment of acute care needs and an opportunity to get releases of information from additional providers in preparation for the comprehensive visit. ***Note:*** In most cases, NC health care providers may share protected health information with other health care providers about a child in DSS custody without written permission. [See the UNC School of Government's guidance, *Sharing Health Information for Treatment*, available in the Fostering Health NC Online Library]

A second visit, called the ***30-day Comprehensive Visit***, should occur within 30 days of placement into foster care.

Follow-up Well-Visits should start within 60 to 90 days of placement, and additional health evaluations (mental health, developmental, educational and dental) should occur based on the child's age. Refer to the AAP Standards of Care for complete details about the frequency and content of these visits.

Care managers should support adherence to the AAP recommendations by ensuring practices are aware of them and by monitoring compliance. Further, care managers, upon receiving copies of *Health Summary Forms* from medical home providers, should upload the forms to Provider Portal (see online library for upload instructions).

D. Guidance on Coding and Billing

Medical home providers often need guidance on how to code and bill services for children in foster care. To address this need (and to dispel the myth that Medicaid will not reimburse for the increased frequency of visits called for by AAP), please refer physicians to Fostering Health NC's *Framework for Foster Care Visits*. This document (found in our online library) contains an exhaustive list of visit options and service codes.

E. Screening for Social-Emotional and Mental Health Concerns

Children in foster care should receive the same well child screenings recommended by the NC Health Check Billing Guide for children who are not in foster care, which include screening for primary general health risks and strengths. [See http://www2.ncdhhs.gov/dma/healthcheck/HC-Billing_Guide_2013.pdf].

Additionally, as a group, children in foster care are at high risk for social-emotional delay due to trauma. Based on early brain development research, children exposed to toxic stressors experience increased risk for delays in social-emotional development. If ignored, such delays can lead to long term problems with health and behavior.

- The **PEDS or ASQ-3** is required at 6, 12, 18 or 24 months, and 3, 4, and 5 years of age. These tools screen for social-emotional concerns as part of a general developmental screening but are not diagnostic tools and a child in foster care benefits from additional, more specific social-emotional screening.
- The **MCHAT** is required at the 18 and 24 month visits--this is a screen for risk of Autism Spectrum Disorder.

Secondary screening tools specific for social-emotional development and mental health concerns include the ASQ-SE, Childhood Depression Inventory, Beck Depression Inventory, PHQ-9 Modified for Teens, Center for Epidemiological Studies Depression Scale, and SCARED. The Pediatric Symptom Checklist (PSC) can be used as a screening tool for primary general health risks and strengths in school age children. The PSC or Youth Pediatric Symptom Checklist (PSC-Y) can be used in adolescents as a secondary screen for learning, social-emotional or mental health concerns. These secondary screening tools should be used in addition to the PEDS, ASQ-3, or PSC (if already used as a primary screen) with children in foster care.

Care managers should make sure practices understand the need for secondary screening and promote the use of the tools named above.

F. Mental/Social-Emotional Health Evaluation and Resources

All children in foster care should have a validated social-emotional screening. Children who have a positive screening or a known mental health condition should have a comprehensive mental health evaluation by a mental health professional in the practice or by referral to a provider in the community. For infants with a positive screen, there is a critical need to perform a comprehensive evaluation for social-emotional concerns and other developmental concerns with the mother/infant dyad and not just the infant.

There are several resources available to assess and address social-emotional development. Commonly used screening tools include PEDS, ASQ-3, and ASQ-SE. [See *Healthy Child and Adolescent Development Promotion and Screening for Risk* in the Fostering Health NC Online Library]

Evidence-based supports and treatments include: Child Parent Psychotherapy, Attachment Biobehavioral Catch Up, and Circle of Security. Older children may benefit from Trauma-Focused Cognitive Behavioral Therapy. A complete list of evidence-based treatments and referrals and community supports for the mother/infant dyad in your community can be found in the Fostering Health NC online library. The NC Child Treatment Program website lists providers trained in these interventions: [See http://www.childtreatmentprogram.org/NCCounties/Index.rails]

Care managers should promote evidence-based, trauma-informed interventions by connecting medical home practices with mental health professionals trained in the modalities listed above.

G. Oral Health

Almost 35% of children and adolescents enter foster care with oral health issues. It is important to link these children with dental homes to have a comprehensive oral health evaluation within 30 days of placement into foster care to address their acute and preventive dental and oral health needs.

Care managers should encourage practices to do fluoride varnishing for children aged three and under during well-visits. [See the CCNC Pediatric Oral Health Guidance: http://dev.ncfahp.org/Data/Sites/1/ccnc-oral-health.docx and the *Framework for Foster Care Visits* handout in the Fostering Health NC Online Library]

H. Supporting the Child's Environment

Because children in foster care have experienced trauma and significant instability, assessing the home environment is a crucial aspect of care. By completing home visits (when possible and appropriate), care managers can add significant value. These visits may offer opportunities to complete Life Skills Progression (LSP) assessments or other developmental screens. Further, the visits may allow for coaching on parenting skills (or referral to learning opportunities such as the Positive Parenting Program: http://www.triplep-parenting.net/nc-en/home/) and education about the impact of trauma and symptoms to watch for.

Care managers can offer support to the parent(s) in ensuring that the child's environment is supportive, developmentally stimulating, and safe. Home visits also offer an opportunity to observe the caregiver(s) and provide referrals if needed. It is important to express support for and facilitate a parent's emotional health and well-being. The health and well-being of a parent is highly correlated with the child's. The following abbreviated screening tools may prove helpful:

Depression Screening: Patient Health Questionaire-2 (PHQ-2):
http://www.cqaimh.org/pdf/tool_phq2.pdf
Substance Use Screening:
http://www.integration.samhsa.gov/images/res/CAGEAID.pdf
Intimate Partner Violence Screening:
https://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Intimate_Partner_Violence

If collaboration with the care team indicates the need to coordinate with educational services, care managers should contact Pre-K programs, school nurses, and other personnel to extend the reach of the child's care plan.

Symptoms and Behaviors That May Be Observed in Children in Foster Care

These may indicate that a child is not coping well and having problems related to social-emotional development and mental health.

Sleep problems

Feeding and Eating issues

Toileting issues (i.e., constipation, encopresis, enuresis, regression of toileting skills)

Self-regulation issues (inability to console or soothe or calm self, impulsive actions)

Frequent severe temper tantrums

Self-abuse (such as biting or hitting self)

Aggressive with other children

Defiance/arguing

Frequently in trouble at school and with peers for fighting and disrupting

Hypervigilance, anxiety, or exaggerated response

Excessive crying or worrying

Flat affect, withdrawn, not smiling, resists cuddling in infants (problems with attachment)

Dissociation
(detachment, numbing, compliance, fantasy)

Difficulty acquiring developmental milestones in infants

Difficulty with school skill acquisition and keeping up in school

Trouble keeping school work and home life organized

Losing details can lead to confabulation, viewed by others as lying

Inappropriate sexual behaviors or gestures

See the Resource Section at the end for more information, especially the AAP's *Helping Foster and Adoptive Families Cope with Trauma*: *A Guide for Pediatricians*.

I. Transitions

Children in foster care experience many kinds of transitions and often all at once. Examples include living in a new home with their foster parents, joining a new foster family, visiting or reuniting with biological parents, starting at a new school or child care, making new friends, and sometimes having a new medical home. Children in foster care need time to adjust. Having a clear routine and structure can be very helpful to children of any age at this time. Transitional objects (e.g., a favorite blanket, stuffed animal or other personal item) can help make transitions easier.

Additionally, shortly after a child/adolescent experiences a change in their foster placement (that is, moves from one home to another), it is important for the provider, the social services case worker, and care manager to discuss the child's health status, particularly their social-emotional health. Changing placements can be traumatic. If the child needs to be seen before the next scheduled visit, the provider can use that office visit as an opportunity to do a screening to find out if the child has experienced trauma.

Adolescents often need to improve their self-management skills in order to plan and prepare for transition from pediatric to adult health care. The AAP offers tools specific to adolescents in foster care working on transition: [See https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/AgingOut%20FINAL.pdf

There are a wide variety of tools available to support youth in transition. [See www.gottransition.org/] Information includes the development of portable medical summaries and emergency plans to help with planning for emergencies.

Finally, The Indiana University's School of Medicine has published a handout with actions parents can take to ease transition: [See http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/IU-Transitions.pdf]

J. Foster Population Data

CCNC Network staff may consider sharing reports (patient summary statistics on utilization, diagnoses, etc.) with local practices serving children in foster care on a periodic basis. This information may be helpful in identifying quality improvement actions.

K. Case Management Across County Lines

County DSS offices sometimes need to place a child with a family or residential facility based outside of the "home" county. When this happens, the case management responsibility remains with the home county, but healthcare services will need to be rendered in the "host" county where the child will live.

Care managers can support these transitions by helping the home county fully leverage Provider Portal for records continuity and care oversight. Further, care managers should assist their DSS counterparts in identifying a host county CCNC practice to serve as the child's new medical home. Every effort should be made to ensure the transitioning child's Medicaid ID card is changed to reflect the *host* county CCNC practice (counties are free to assign *any* CCNC practice on the Medicaid ID card; they are not limited those within their own county). To do this, the home county will need to obtain the National Provider Identifier (NPI) number and locator code for the host county CCNC practice.

NOTE: While assigning a "straight" or "open" Medicaid ID card may add flexibility in terms of where a child may be seen, doing so triggers the loss of two important tools: 1.) care management services from CCNC and 2.) the ability to view case management notes *across* CCNC networks. As a result, care managers should urge their DSS counterparts to assign CCNC practices on all Medicaid ID cards for children in foster care.

If a bridge period is needed to cover the time between a child's move and the re-issuing of their Medicaid ID card, the home county DSS office can make a "Carolina ACCESS Override Request" to enable the host county medical home to provide services (and bill for those services) until the ID card is updated. To make this request, the home county DSS should contact the NC Division of Medical Assistance, Managed Care Section at 919-855-4780. The Division will need the child's Medicaid ID number, NPI of the child's *current* CCNC provider, NPI (or name and address) of the host county practice, locator code for the host county practice, and anticipated dates of service in full month increments (i.e. 3/2015 – 4/2015).

When a change in placement results in a change in Network, *all* documentation should transfer:

- Network care manager to Network care manager
- Practice contact to practice contact

L. Additional Resources

Foster Care

AAP Healthy Foster Care America: www.aap.org/fostercare

Mental Health

AAP Mental Health Initiatives: www.aap.org/mentalhealth

Trauma

AAP's *Helping Foster and Adoptive Families Cope With Trauma: A Guide for Pediatricians*: http://www.aap.org/traumaguide

National Child Traumatic Stress Network: www.nctsn.org

Child Trauma Academy www.childtrauma.org

AAP Medical Home for Children and Adolescents Exposed to Violence: http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/Pages/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence.aspx

Early Brain Development

AAP: Early Brain and Child Development: http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/EBCD_Well_Child_Grid.pdf

Center on the Developing Child at Harvard University: www.developingchild.harvard.edu

Zero To Three: http://www.zerotothree.org/about-us/areas-of-expertise/free-parent-brochures-and-guides/

Contact Information for Local County DSS Offices

http://www.ncdhhs.gov/dss/local/index.htm

Best Practices for CCNC & CC4C was developed by the Fostering Health NC State Advisory Team, with contributions from Marian F Earls, MD, MTS, FAAP, Director of Pediatric Programs for Community Care of North Carolina (CCNC).