

# Fostering Health NC - Best Practices for Private Agencies

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

**What is Fostering Health NC?** There are more than 11,000 children in DSS custody who are placed in foster care in North Carolina. These children often have special health care needs. Because of the circumstances that led them to be placed into foster care, their physical, developmental, mental/social-emotional, and oral health care may have been inconsistent and impacted by crisis or injury. Fostering Health NC (FHNC), a project of the North Carolina Pediatric Society, is focused on building and strengthening medical homes for infants, children, adolescents, and young adults in DSS custody through integrated communications and coordination of care through a unique partnership among local Departments of Social Services, Community Care of North Carolina (CCNC) Networks, the pediatric care team, foster parents, the child, and the child’s family. In instances where the child is placed with a private agency, this agency is an additional integral piece of that partnership

## A. Benefits of Medical Homes

Medical homes, frequently referred to as the primary care provider (PCP), provide a single point of entry to a system of care that facilitates access to medical and nonmedical services. A medical home allows primary care providers (i.e. pediatricians or family physicians), parents, child welfare professionals, and other stakeholders to identify and address all physical and mental health needs of the child promptly and as a team.<sup>1</sup> All children benefit from medical homes through the establishment of a consistent, ongoing relationship with a primary care provider and team who know the child well. Having a medical home also reduces the likelihood of a child needing to utilize urgent care in place of the primary care physician. This consistency is particularly helpful for children in foster care. A medical home preserves the relationship children have with their doctors and ensures medical records don’t get lost, even when they return home or change placements.<sup>2</sup>

## B. CCNC and Care Management

Community Care of North Carolina (CCNC) has a pivotal role in the Fostering Health NC Initiative. CCNC is a statewide, community-based program with a history of developing primary care medical homes for Medicaid recipients. With 14 regional networks across all 100 counties in North Carolina, CCNC equips providers to offer comprehensive, coordinated, high quality care and provides “boots on the ground” support. CCNC Care Management is a set of interventions and activities that address the health care of a population to promote quality, cost-effective care. Care Coordination for Children (CC4C) care managers are employed through the county health departments and focus on children birth-5 years of age while CCNC Care Managers focus on the population

5 years of age and older.

Care Managers:

- provide multidisciplinary care coordination for high risk patients
- support pharmacy initiatives to maximize patient safety, medication adherence, and cost effective medication management
- foster integrated behavioral and physical health care and holistic care for special populations
- link major segments of the local health care system (hospitals, public health, primary care providers, pharmacies, specialists, behavioral health providers, social services, community resources etc.)
- address underlying social determinants of health

Care Management is provided via face-to-face encounters and telephonic phone contact. These face-to-face encounters include patient and family education as well as referrals. CCNC can play an important role in helping children and youth in foster care avoid fragmented health and behavioral health services.

## C. Facilitating Information Flow

To provide optimal care of youth in foster care, private agencies need important background information on the child’s health history. Private agency staff, collaborating with DSS social workers and CCNC network staff, can ensure the foster child is linked to the appropriate medical care and receives the care needed. Private agencies can obtain the child’s CCNC care manager information from the child’s DSS social worker. If the child does not have a CCNC care manager, or if it is not known, the DSS social worker will often make the initial referral to CCNC. However, if the

<sup>1</sup> Practice Notes, Vol. 15 #2, 2010

<sup>2</sup> ibid

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## C. Facilitating Information Flow (continued)

DSS social worker is unable to, or requests assistance in making contact, the private agency may make the initial contact to CCNC. Upon obtaining a release of information, the private agency may make a referral to CCNC and may also work with the care manager assigned to a child's case. A general referral form, which can be used for any CCNC network, has been developed to aide in the referral process. Using a team approach, the private agency staff, DSS social worker and CCNC/CC4C can work together to ensure a good link to a medical home, education and review of medications, and coordination of links to appropriate community agencies. To initiate the flow of this information, private agency staff should work with the DSS social worker to ensure CCNC's patient information exchange platform, known as Provider Portal, is being accessed. Using Medicaid claims data, Provider Portal can enable the DSS social worker to verbally provide care team contact information, office visit and hospital stay histories, current and past medications (along with information on whether or where prescriptions were filled) and immunization records to the private agency caring for the child. There are several documents that have been developed to assist in this process including the CCNC network contacts map, a general referral form, and the Fostering Health Flowchart. These documents can be accessed <http://www.ncped.org/?page=FHNCLibrary>

## D. Types of Medical Home Visits

According to the AAP Standards of Care, the **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 obtain releases of information from additional providers in preparation for the comprehensive visit. When calling the physician's office, it is helpful to clarify that a 15-minute wellness visit is all that is needed.

The second visit, called the **30-day Comprehensive Visit**, should occur within 30 days of placement into foster care, unless medically necessary to see the child sooner. This visit would be typical of a physical or well-child check.

**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 and needs.

To align care with AAP-recommended visits, the NC Division of Social Services published a new set of health forms.<sup>3</sup> These Health Summary Forms take the place of DSS-5243 and DSS-5244, which have been removed from the NCDSS publications website. For each child entering DSS custody, the DSS worker should complete a **Health History Form (DSS-5207)** and send it to the medical home approximately one week prior to the child's 30-day Comprehensive Visit. Private agencies should receive a copy of this form as well.

The PCP should complete **Health Summary Forms** after each of the recommended visits:

- Health Summary Form—Initial Visit (DSS-5206)
- Health Summary Form—30-day Comprehensive Visit (DSS-5208)
- Health Summary Form—Well Visit (DSS-5209)

The PCP can attach a summary of the visit to these DSS forms and only enter information on the form that is not included in the summary. They do not have to duplicate information that is in the attachments. These forms may be found on the DHHS forms website and on the FHNC Online Library: <http://www.ncped.org/?page=FHNCLibrary>

## E. Frequency of Medical Home Visits

Children in foster care need to be seen early and often to identify health issues before they become crises. 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 and the AAP website<sup>4</sup>.

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:** Should be seen every 6 months and at times of significant change

<sup>3</sup> See Dear County Director Letter dated 4/15/2016

<sup>4</sup> <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx>

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## F. Administrative Rules for Medical Exams

Administrative rules regulating the timing and frequency of medical examinations for children placed in foster homes and residential child care facilities are found in 10A NCAC 70G .0510 (e) and 10A NCAC 70I .0604 (a) respectively. The regulation, which is the same regardless of placement setting, requires the child to have a medical examination 12 months prior to admission or no later than two weeks after admission. The new standards put forth by the American Academy of Pediatrics (AAP) and the Child Welfare League of America (CWLA) for foster children in the custody of a county Department of Social Services **requires a different schedule and frequency for medical examination**. While, currently, administrative rule has not changed, the increased frequency for medical examinations set forth by AAP is considered **best practice**. While some county DSS agencies have fully integrated these changes into their practice, others have not. At this time, private agencies will be held to the requirement that is outlined in administrative rule as a minimum standard. It is expected that administrative rules will be revised to reflect these AAP standards at a future date.

## G. 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 may be found in the Fostering Health NC online library and contains an exhaustive list of visit options and service codes. <http://www.ncped.org/?page=FHNCLibrary>

## H. Mental/Social-Emotional Health Evaluation and Resources

All children in foster care should have a validated social-emotional screening. Based on early brain development research, children exposed to toxic stressors experience an increased risk for delays in social-emotional development. If ignored, such delays can lead to long term problems with health and behavior. 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 be referred to a provider in the community. It is important to note that before a child can have a mental health assessment parental consent on the DSS 1812, General Authorization for Treatment and Medication, must be obtained. This consent is obtained by the DSS social worker, with a copy of the consent given to the provider.

There are several resources available to evaluate and address social-emotional development. It is important for the private agency to work with the child's DSS social worker to coordinate the scheduling of and participation in both the initial social-emotional screening, as well as follow through with any recommendations that come from the initial screening. The private agency should, in conjunction with the DSS social worker, promote evidence-based, trauma-informed interventions for referrals for children in their care to mental health professionals trained in evidence-based supports and treatments.

## I. Transitions

Private agencies should understand their role as it relates to medical care when children change placements to ensure that appropriate and consistent medical care is received.

Children in foster care experience many transitions and often all at once. Examples include joining a new foster family, visiting or reuniting with biological parents, starting at a new school or daycare, making new friends, having a new medical home, or transitioning from pediatric healthcare to adult healthcare. Prior to, or shortly after, a child/adolescent experiences a change in their foster placement, it is important for the receiving private agency to communicate with the DSS social worker to discuss the child's health status. This conversation should include identifying the CCNC Care Manager, the healthcare provider, and any other providers the child is seeing including a therapist and psychiatrist. Changing placements can be traumatic. If the child needs to be seen before the next scheduled visit, the medical provider can use that office visit as an opportunity to screen for trauma. When transitioning, it is important that the receiving private agency obtain a thorough medical history on the

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## I. Transitions (continued)

child as soon as possible, preferably *before* the child comes into care with the new private agency. The receiving private agency will want to ascertain the date of the child's last medical appointment, well-child visit, therapy session, and psychiatric/med management appointment, as well as any upcoming appointments that are scheduled or need to be scheduled. The receiving agency will also want to obtain copies of the child's medical forms DSS-5206, DSS-5207, DSS-5208, and DSS-5209 if they are available. If the child is transitioning from another county, the receiving agency will need to determine if the child will need to find a new healthcare provider and/or mental health provider, including therapy and medication management. Relationships with the child's DSS social worker and the CCNC Care Manager are key in identifying a new medical home when needed.

If the receiving private agency is able to obtain documentation of all medical care that has occurred since the initial DSS 5206 and 5208 were completed, and medical care was provided based on the enhanced health care schedule, it may not be necessary to have these forms completed when a child transitions agencies. However, if there are gaps in medical care, or documentation of medical care has not been received, it may be necessary to have these forms completed again to ensure that all information is accurate and up-to-date. Having conversations with the child's DSS social worker and CCNC Care Manager will help determine what appointments need to be made and which forms should be completed.

## J. Oral Health

Almost 35 percent 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 to address their acute and preventive dental and oral health needs. The American Academy of Pediatrics recommends every child have a dental home established by 1 year of age. Social workers or caregivers should inquire about practices doing fluoride varnishing for children aged three and under during well-visits. [See the CCNC Pediatric Oral Health Guidance:

<https://www.communitycarenc.org/media/files/oral-health-dental-varnishing-2015.pdf>

## 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*.

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## J. Oral Health (continued)

Administrative rules regulating the timing and frequency of dental examinations for children placed in foster homes and residential child care facilities are found in 10A NCAC 70G .0510 (g) and 10A NCAC 70I .0604 (e) respectively. The regulation, which is the same regardless of placement setting, requires the child to have a dental examination 12 months prior to admission or no later than six weeks after admission.

## K. Additional Resources

### Foster Care

AAP Healthy Foster Care America: [www.aap.org/fostercare](http://www.aap.org/fostercare)

### Mental Health

AAP Mental Health Initiatives: [www.aap.org/mentalhealth](http://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](http://www.nctsn.org)

Child Trauma Academy [www.childtrauma.org](http://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>

**Abbreviated Screening Tools for Caregivers** may prove helpful in determining if a referral is needed:

Depression Screening: Patient Health Questionnaire-2: [http://www.cqaimh.org/pdf/tool\\_phq2.pdf](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](https://www.acog.org/Resources%20And%20Publications/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/Intimate%20Partner%20Violence)

### 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](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](http://www.developingchild.harvard.edu)

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