

Fostering Health NC - Best Practices for Providers

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

www.ncped.org/fosteringhealthnc

What is Fostering Health NC? There are approximately 11,000 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. Identifying Patients in Foster Care & Obtaining Medical Records

Children entering foster care are in the custody of the local Department of Social Services (DSS) and DSS is responsible for collecting and providing medical and other relevant history about these children and young adults. As part of your collaboration, DSS should work with you 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]. The vast majority of children in foster care are categorically eligible for Medicaid. Your Community Care of North Carolina (CCNC) network staff and care managers (CCNC network care managers and local health department CC4C care managers) have access to Medicaid claims data through the CCNC Provider Portal and to information about individual patients through the Case Management Information System (CMIS). Your care managers can help you identify existing children in foster care already in your practice and access supplemental patient history information. Additionally, the number of children within your county who are in DSS custody can be found on the *Child Welfare, Work First, and Food & Nutrition Services in North Carolina* database [ssw.unc.edu/ma/].

B. Frequency of Visits

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 American Academy of Pediatrics (AAP) and Child Welfare League of America (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 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/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx].

Summary of the AAP Standards: Children & Young Adults Should Be Seen Early and Often Upon Entry into Foster Care

- **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** (e.g., change in placement, reunification): Should be seen every 6 months

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.

C. Types of 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 focused on health conditions requiring prompt attention that should be considered when making placement decisions. It is also an opportunity to identify additional information to gather for the Comprehensive Visit. **Note:** In most cases, NC health care providers may share protected health information with other providers about a child in DSS custody without written permission. [See the UNC School of Government’s guidance on [Sharing Health Information for Treatment](#) for details and legal citations, 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, unless medically necessary to see the child sooner. Before the visit, the provider reviews all available data and medical history about the child and identifies other records to be obtained for review. This visit is an opportunity to identify developmental and mental health conditions requiring attention, assure appropriate dental and educational screening/assessments are done, and to develop an individualized health care plan to be shared with those responsible for the child’s care and well-being.

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C. Types of Visits (continued)

Follow-up Well-Visits begin within 60 to 90 days of placement and are focused on primary and preventative health care services. These visits provide opportunities to assure any referrals and/or treatments recommended during the Comprehensive Visit have been done, share information with those responsible for the child's care and well-being, and review the rationale for the enhanced visit schedule with foster families. Refer to the [AAP Standards of Care](#) for complete details.

D. Foster Care Visit Options and Codes

Please see the [Framework for Foster Care Visits](#) handout in the Fostering Health NC Online Library for visit options and codes for the care of children and youth in foster care.

E. Sharing Info Among Care Team Members

To align care with AAP recommendations, the NC Division of Social Services published a new set of health forms (DSS-5206, 5207, 5208, and 5209). Primary care providers will need to complete the [Health Summary Forms](#) for the Initial (DSS-5206), Comprehensive (DSS-5208), and follow-up Well-Visits (DSS-5209) and share a copy with DSS on the day of the visit. Providers should receive a completed [Health History Form](#) (DSS-5207) from DSS one week prior to the Comprehensive Visit.

In order to maximize the utility of the important information collected on these forms, care team members should consider leveraging Provider Portal's document upload feature to include these forms in the Portal system.

Important: While Provider Portal offers robust claims-based information, it has a notable limitation. Drugs used to treat substance abuse will **not appear** on medication lists in Provider Portal. Such drugs include: Naltrexone – Revia, Vivitrol; Disulfiram – Antabuse; Acamprosate – Campral; Buprenorphine – Subutex, Buprenex; Buprenorphine/naloxone – Suboxone, Zubsolv.

In cases when a child experiences a placement change that includes establishing a new medical home, all documentation should transfer (care manager to care manager and practice contact to practice contact). Before the visit, the receiving medical provider reviews all available data and medical history about the child and identifies other records to be obtained for review. Providers can verify with DSS that DSS has/will update the child's Medicaid ID card to reflect the new medical home. [For more on Medicaid ID card changes and overrides, see the [Best Practices for DSS Social Workers](#), Section K]

F. Screening for Mental and Social-Emotional Health Concerns

Children in foster care should receive the same well-child screenings recommended by the NC Health Check Program Guide for children who are not in foster care, which include screening for primary general health risks and strengths. [See <https://dma.ncdhhs.gov/medicaid/get-started/find-programs-and-services/health-check-and-epsdt> for the Program Guide – scroll to More Information, click on Health Check Program Guide.]

Children in foster care are at high risk for social-emotional delay due to trauma and exposure to toxic stress. Social-emotional development is impacted early and, if ignored, can lead to long term problems with health and behavior.

- General Developmental and Behavioral screening with the **ASQ-3, PEDS, or PEDS DM** is required at well-visits at 6, 12, 18 or 24 months, and 3, 4, and 5 years of age and should be reported as **96110 EP**. 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 R/F** is required at the 18 and 24 month well-visits and is billed as **96110 EP**. This is a screen for risk of Autism Spectrum Disorder.

Screening tools specific for social-emotional development and mental health concerns include the ASQ-SE, Baby PSC, Preschool PSC, Childhood Depression Inventory, Beck Depression Inventory, PHQ-9 Modified for Adolescents, Center for Epidemiological Studies Depression Scale, and SCARED (anxiety screen). 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 social-emotional 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. Additional screening tools for children and adolescents can be found in the [Healthy Child and Adolescent Development Promotion and Screening for Risk](#) handout found in the Fostering Health NC Online Library. Screening with any of these tools can be billed using **96127 (with EP modifier if at a well-visit)** for Medicaid or Health Choice. Medicaid and Health Choice allow the use of two units of **96127** per visit.

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G. Mental/Social-Emotional Health Evaluation and Resources

By virtue of their socioeconomic status, many children and youth in Medicaid experience social determinants that confer risk and impact their health. Thus, all children in foster care should have a validated social-emotional screening. Children who have a positive screening (including maternal depression screening, billed as **96161 EP**) 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 to evaluate and address social-emotional development in infants and young children and use of these resources is increasing across North Carolina. Again, it is important to assess the mother/infant dyad and not just the infant. CC4C care managers are a great resource to help you identify local resources for children under five years of age. [See www.communitycarenc.org/emerging-initiatives/care-coordination-children-cc4c/]

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. The NC Child Treatment Program provides a list of providers trained in these interventions. [See www.ncchildtreatmentprogram.org/]

Psychotropic Medication Management: CCNC-authored guidelines for psychotropic medication management are available on the Fostering Health NC Online Library and the CCNC website – see *Best Practices for Medication Management for Children & Adolescents in Foster Care* and *Psychotropic Medications in Children and Adolescents: Guide for Use and Monitoring*.

H. Oral Health

Almost 35% of children and youth 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. Fluoride varnishing can be performed by your staff for children under three and a half years during a visit. North Carolina's *Into the Mouth of Babes* program provides training and resources to medical providers on preventative oral health care for patients who receive Medicaid [For more information, see *Framework for Foster Care Visits* handout].

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 of this handout for more information, especially the AAP's *Helping Foster and Adoptive Families Cope with Trauma: A Guide for Pediatricians*.

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I. Interacting with Biological Parents/Families

Often the goal is to reunite children with their biological parents. Thus, making every effort to uphold the dignity of biological parents is important to families. Providers can do this by carefully safeguarding information they receive about a child's case and involving biological parents to the maximum extent possible in decisions about care. During visits, especially visits involving both biological and foster parents, providers should ask the child how he/she refers to each parent figure and use those terms. Providers should use the term "child in foster care," rather than "foster child." Because the health and well-being of a parent impacts the child's health and well-being, it is important for providers to support and facilitate the parent's emotional health and well-being, by providing referrals when needed. Finally, following reunification or adoption, providers should consider monitoring the child closely and see the child based on the child's continued risk which includes keeping up with specialists, including mental health.

J. 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 biological parents, starting at a new school or child care, leaving behind friends and 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 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 the CCNC/CC4C 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. As a provider, you can help assess their transition readiness with a variety of tools.

The AAP offers tools specific to adolescents in foster care working on transition: [<http://bit.ly/2qnKG2S>]

Additionally, there are a wide variety of tools for both pediatric and adult health care providers on how to address and promote health care transition, which also align with the 2010 AAP/AFAP/ACP policy. [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 including tips for parents: [www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/IU-Transitions.pdf]

K. Working with School Nurses

The *Best Practices for School Nurses* explains the benefits of local DSS staff, care managers, and medical providers working with school nurses, who are uniquely positioned to support care plans and monitor well-being of children. For school nurses, this guide covers sharing information and specific ways to support the environment of children in foster care.

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L. Suggested Resources

Foster Care

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

Mental Health

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

Johns Hopkins Bloomberg School of Public Health, Center for Mental Health Services in Pediatric Primary Care:
A Guide to Psychopharmacology for Pediatricians web.jhu.edu/pedmentalhealth/Psychopharmacolog%20use.html

Trauma

AAP's *Helping Foster and Adoptive Families Cope With Trauma: A Guide for Pediatricians*: 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: The Resilience Project:
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

Guidelines for the Evaluation of Children in the Emergency Department Setting co-authored by The NC Pediatric Society's (NCPeds') Committee on Child Abuse and Neglect and The North Carolina College of Emergency Physicians (NCCEP): www.ncped.org/resource/collection/8E0E2937-00FD-4E67-A96A-4C9E822263D7/ED_Guidelines_Final_1_2015.pdf

Early Brain Development

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

Bright Futures: brightfutures.aap.org

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

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