Bridging the Gap between Child Welfare and Child Health Care:
A Statewide Systems Building Project Utilizing the Medical Home

www.ncpeds.org/fosteringhealthnc

Susan Foosness, MSW MPP
Senior Consultant, Public Consulting Group
sfoosness@pcgus.com

Leigh Poole Lodder, MA
Implementation and Evaluation Manager, Fostering Health NC
leigh@ncpeds.org

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Objectives

• Understand how various North Carolina systems are organized
• Learn about the Fostering Health NC model for medical homes for children in foster care
• Understand the health challenges facing children in foster care
• Understand the AAP-recommended standards of care for children served by the foster care system
• Learn about statewide policy and program changes
• Learn about what Fostering Health NC has accomplished and what it can mean for children in foster care
Geographic context for this project:

- 100 counties
- State-supervised, county-administered (similar to VA, PA, CA, MN, and others)
- Strong local autonomy supports innovation, flexibility, local collaboration
- Limited state oversight, financial skin in the game
- Disparity in county resources for CW (especially urban vs. rural counties)
- 10,000 children in foster care and growing in recent years
Community Care of North Carolina (CCNC)

- Nationally recognized managed primary care program for majority of Medicaid recipients ($1.4M patients)
- Public-private partnership between physicians and NC Medicaid program
- Primary care physicians agree to work on quality improvement (5,000 providers)
- 14 regional networks, generally 501(c)(3) organizations
- Networks utilize medical home model (cooperative, coordinated care) to optimize care
- Unique features:
  - Population health approach to high risk/high cost patients (asthma, diabetes, sickle cell, transition age youth, foster care)
  - Network care managers, pharmacists, psychiatrists, behavioral health coordinators
  - Care managers are extension of medical home – can see patient in their home, at school, etc.
Community Care of North Carolina (CCNC)

https://www.youtube.com/watch?v=J4rbxvRGKGI

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- https://www.youtube.com/watch?v=J4rbxvRGKGI
- 0:00 – 1:56
LME/MCOs are NC’s managed care system for behavioral health services

- Covers all Medicaid recipients and oversees some county funds for indigent/underinsured population
- 7 LME/MCOs currently with plan to collapse into 4
- Behavioral health providers must be enrolled with LME/MCO to provide services under their region
- Challenge for CW because Medicaid card is tied to county with custody (requires agreements if child has Medicaid in county A, but lives in county B in a different catchment area)
- Another challenge is the lack of behavioral health providers across state; all patients (not just CW) suffer from access to behavioral health services
NC Pediatric Society is the state affiliate Chapter of the American Academy of Pediatrics
- 2,000 pediatrician and pediatric health professional members
- Partner with pediatricians, Community Care of North Carolina and its regional care management networks, and many parts of the NC Department of Health and Human Services – Division of Social Services, Office of Rural Health, Division of Medical Assistance, and Division of Public Health
- Advocates have been working on foster care medical homes in NC since 2008; project received funding in 2014
- NC Pediatric Society wrote NC’s plan in 2013 through contract with NC Division of Social Services, in response to the federal law, *Fostering Connections to Success and Increasing Adoptions Act of 2008*
- Program
  - Guided by the AAP Standards of Care for children and youth in foster care
    - Recommend children and youth in foster care be seen early and often while in care
    - Consider Children and Youth with Special Health Care Needs (CYSHCN)
    - Healthy Foster Care America: www.aap.org/fostercare
  - Informed by research that shows that the medical home model, coupled with care coordination, improves health care for children in foster care
  - Informs state level policy development to resolve long-standing barriers to collaboration in the field

**Fostering Health NC**

*Connects children in foster care with a medical home that can meet their special health care needs*

Led by the North Carolina Pediatric Society (NCPeds)

Funded since 2014 – combination of federal, private, and state funding

Operationalizes NC’s *Health Oversight and Coordination Plan (HOCP)*

**Program Approach**
- AAP Standards of Care for children and youth in foster care
- Policy development
- Strategic partnerships
Children in foster care require significant coordination, attention to their special health care needs, and an understanding and attention to social behavioral needs and the impact of trauma. This model encompasses entities that can support the best outcomes for the foster care population.


The program leverages strategic partnerships among 3 key stakeholder groups: local social service agency, care management network, and the medical home.

**Medical Home**
- Implement the AAP recommended schedule of visits for children in foster care ("early and often")
- Ensure children receive appropriate social-emotional development screening, and referrals

**Regional Care Management Network**
• The “glue”
• Care manages children and youth in foster care – one of their priority patient populations
• Communication and documentation
• Access to Medicaid claims data on children in foster care custody (provides window into health care needs)

County Department of Social Services
• Communicate when child comes into care/changes placements (via referral to PCP and/or care manager)
• Automatic referrals for children 5 and under
• Supplies completed health history form to provider

Mental Health
• Ideal is integrated behavioral health through the medical home which is led by the PCP
The Foster Care Population

*Children and Youth with Special Health Care Needs* – what does that mean?

- Chronic physical problems (e.g., asthma, anemia, visual loss, hearing loss, and neurological disorders)
- Many have a history of prenatal (maternal) substance exposure and/or premature birth
- Many enter foster care with oral health issues
- Many with developmental and behavioral concerns and conditions
- Small percentage are medically fragile or complex
Because the AAP and the CWLA consider children in foster care to be Children and Youth with Special Health Care Needs (CYSHCN), the AAP recommends an enhanced periodicity schedule.

The AAP Standards of Care for children in foster care 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.

In NC, there is no limit on the number of well-child visits since these enhanced visits are medically necessary.
NC State DSS policy: Used to be that the “physical” was scheduled within 7 days; now states it should occur within 7 days. Most communities we work with are able to get most of the children in between 3-7 days for Initial Visit.

**Initial Visit**: focused on acute care needs

- Identify health conditions requiring prompt medical attention
- Identify health conditions that should be considered in making placement decisions

**Comprehensive Visit**: multidisciplinary health, mental health and developmental assessment within one month of placement

- Review all available data and medical history about the child or adolescent and identify other records to be obtained for review
- Identify medical conditions
- Identify developmental and mental health conditions requiring attention
- Assure appropriate dental and educational screening/assessments are done
- Develop an individualized health care plan to be shared with those responsible for the care and well-being of the child/youth
Ongoing Follow-up Well-Visits: primary and preventive health care services

- Assure that any referrals and/or treatments recommended with comprehensive assessment have been done
- Share all information with those responsible for the care and well-being of the child/youth
- Review with foster families the rational for the enhanced health schedule
Systems Level Work

- Interdisciplinary and multi-agency State Advisory Team
- Education and Technical Assistance – at all levels
- County Level (“grassroots”) approach
- Sustainability (gaining ‘buy-in’ at State level)
- Showing the model works: Results
- Tools and Resources developed by State Advisory Team: Online Resource Library

- The project spreads best practices, provides local implementation support across the state
- Guided by a State Advisory Team comprised of over 50 professionals in child health, mental health, pharmacy, and social services.
  - Expertise has helped develop best practice documents and policy changes
  - Fostering Health NC Online Library: http://www.ncpeds.org/fosteringhealthnc
• Legal pathway for Counties/County DSS agencies to access Medicaid claims data on children in DSS custody
  • Medicaid claims information (such as recent office, emergency department, inpatient and behavioral health visits; medication fill history; and immunizations) is critical in making care decisions for children in foster care
  • The system provides continuity of medical records for children in foster care in the absence of a statewide case management system or Health Passport when completed Health Summary Forms are uploaded
• Health Summary Forms encourage exchange of information among the physician, care managers, and social services staff
• Changes to NC Juvenile Code (N.C.G.S. 7B-505.1)
  • Established who can consent for treatment of children/youth in foster care under various circumstances
  • Codifies physician access to confidential information
• Several memos/best practices address confidentiality and sharing of information – see Fostering Health NC online library resources - Sharing Information www.ncpeds.org/fosteringhealthnc
• Framework for Foster Care Visits

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<th>Solutions</th>
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<td>Unknown medical history</td>
<td>• Legal agreement for county Dept. of Social Services to access Medicaid claims data (TECCA)</td>
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<td>Sharing information</td>
<td>• Health Summary Forms</td>
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<td>• Changes to NC Juvenile Code</td>
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<td>Billing and coding for visits</td>
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<td>Medication management</td>
<td>• Best Practices for Medication Management for Children &amp; Adolescents in Foster Care</td>
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<td>Cross-county placements</td>
<td>• Case Management Across LME/MCO Catchment Areas</td>
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• Includes the components and codes for billing for each of the three types of recommended visits (Initial, 30-day Comprehensive, and Ongoing Well-Visit)

• **Best Practices for Medication Management for Children and Adolescents in Foster Care**
  - Red flag criteria
  - Medication Review Request Form (request for a network pharmacist to do a med review)
  - High alert meds – divided into 3 categories: Medications that can cause withdrawal symptoms if stopped abruptly, Medications that would be risky to stop due to potential disease re-occurrence, Medications that might be needed in an emergency

• **Case Management Across LME/MCO Catchment Areas**
  - Suggested best practice protocol when a county DSS case worker needs to place a child/youth outside the home LME/MCO
From 2015-2017, Fostering Health NC 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. Almost 3,100 children and youth in foster care in North Carolina (or 29%) are served by a medical home working to implement the Fostering Health NC foster care medical home model.

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.
The implementation map shows the various degrees of current program implementation across the state.

- 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.
- Green stripe – counties 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.
- Handful of counties in darker green - where the regional CCNC network and at least one medical practice are working together to implement the model. In some of these counties the NC Division of Social Services staff 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.
- Light gray areas of the map - 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 community care networks in these more rural areas and anticipate some of those counties will sign on, with continued support.
Around 71% of children and youth in foster care in NC receive their regular schedule of well-visits.

At least 2 of the age groups are ahead of the 2015 HEDIS national Medicaid MCO average.

More work needs to be done regarding well-visit rates for children within the first 15 months of life.

Well-child visits have remained the same (61%)

Children in this age range lag behind their non-foster peers (61% vs. 67%) and just above the 2015 HEDIS national Medicaid MCO average of 59.8%
Results

• 54 (out of 100) County Departments of Social Services using the Health Summary Forms
• 49 (out of 100) County Departments of Social Services have a legal agreement to access Medicaid claims data
• Cost data for children in foster care show 4% increase between 2016-2017
• Cost data show children enrolled with CCNC care management network cost less per member per month than those not enrolled
• ED utilization has held steady over past year
Local Stakeholder Input

- Greatest changes reported
- Benefits to involving the Care Manager
- Benefits to involving the Network Pharmacist
- Components difficult to implement
- Lots of love for program/seen as a resource and asset
- What still needs to happen

Greatest changes reported

- Better communication between county DSS, the medical home, network staff (care managers and pharmacists), school nurses, and families. Better communication attributed to relationships built among staff at partner agencies, use of the Health Summary Forms, and standard language regarding the types of medical visits.
  - Participants noted that building strong working relationships and working together resulted in: an increased response from their partner agencies when they reached out about a specific child, identifying holes within the process where children were slipping through, and greater appreciation for their peers and deeper understanding of their work which led to identifying ways in which they could support one another.
- Greater understanding of medical needs of children in foster care and why the enhanced schedule is recommended
- Knowing more about a child’s health history (especially medications filled, when children have been to the doctor, diagnoses) by accessing Medicaid claims data

Benefits to involving the Care Manager

- Discovering unknown medical conditions
- CM can serve as an advocate for child/youth
• Ensuring child receives referrals for needed services

**Benefits to involving the Network Pharmacist**
• Medication reviews/comfort with med regimen or comfort with changes to med regimen
• Ensuring children have been properly diagnosed (where’s the assessment to support diagnosis?)
• Obtaining overrides for prescriptions

**Components difficult to implement**
• Initial Visit within 72 hours
• Gaining administration buy-in
• Differentiating between case worker and care manager roles
• Ongoing education/re-training

**What still needs to happen**
• Prompt access to mental health care
• Consistency among counties and more continuity when children are placed out of county
• Written policies at state level (NC Division of Social Services manual)
Fostering Health NC – one of four state-based organizations to be recognized at this level

Written into North Carolina’s proposed Medicaid 1115 waiver

- AAP’s National Center for Medical Home Implementation as an innovative and promising practice (see http://bit.ly/2mnNoTx)
- Program written into North Carolina’s proposed Medicaid 1115 waiver for continued implementation statewide
David before Fostering Health NC

New primary care provider, New school
Trouble sleeping, constipation, picky eater and school behavior issues
Difficulty getting an appointment (it took 3 weeks)
Referral to GI specialist (more tests)
ADHD testing (prescribed stimulants)
Moved to another home, maybe another county
David is experiencing more trauma as a result of this experience
So far....

- Continuity of health care forms
- TECCA (DSS has access to medical claims)
- Foster Parent support/training
- Medical Notebook
- Care Management
- Trauma Informed Care
David after receiving Trauma Informed Care

David is assigned to a regional CCNC network care manager to coordinate medical needs.
David is able to keep his own doctor.
David still has trouble sleeping, constipation, picky eater and behavior issues at school.
The trauma informed care manager educates & supports foster family & school teacher.
Primary Care Provider supports foster family and treats constipation with Mirilax; He refers David to TF-CBT.
On Saturdays David’s mother brings a list of David’s favorite foods for his foster parents.
David feels safe.