



HEALTH OF CHILDREN IN FOSTER CARE IN DELAWARE

RECOMMENDATIONS

Submitted by the Delaware Task Force on the Health of Children in Foster Care

To the Delaware General Assembly

May 2015

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The Task Force on the Health of Children in Foster Care was authorized by the Delaware General Assembly in June 2014. Children in foster care represent some of the most vulnerable children in our state. They have typically experienced a range of adverse experiences that can include not only child maltreatment, but also the related issues of poverty, exposure to violence, and housing instability. The combination of these risk factors can result in serious negative outcomes in both emotional and physical health. While children are in the custody of the state, there is an important opportunity to assess and respond to their needs. In doing so, there is an opportunity to affect the course of their development, not only as children, but across their life span.

The Task Force was charged with painting a picture of the health of children in foster care. Telling this complex story using Medicaid claims data offers a first overview of their complex health needs. The work of the Task Force started a dialogue between public and private child welfare providers, health providers, and the broader community about the unmet health needs of children in foster care. It opens the doors for engagement in conversations about how we can provide better care by collaborating across the silos of government, medical, and mental health systems to improve care, not only for children in foster care, but also for other children who experience poverty or trauma.

We appreciate all of the significant time and effort shared by the members of the Task Force. We thank Steven Peuquet, Mary Joan McDuffie, and Erin Knight at the University of Delaware's Center for Community Research and Service for their expertise and shared vision in the importance of this work. In addition, the Task Force would not have been possible without the leadership and support of Representative Melanie George Smith. We also appreciate the support from Jay Greenspan, Mary Kate Mouser, and Diane Abatemarco of Nemours, who helped to champion the need for this Task Force.

*Vicky Kelly
Co-Chair
Director
Division of Family Services*

*Cathy Zorc
Co-Chair
Pediatrician
Nemours*

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Children in foster care, both in Delaware and across the nation, include those who have typically experienced lives of significant adversity—poverty, housing instability, food insecurity, and exposure to violence both in their communities and homes—prior to their entry into foster care. This challenging

Daniel is a 16 month old boy who entered foster care after being abandoned by his birth mother. Two weeks after being placed with a foster family, Daniel's foster family called his doctor because he had a cough. The child's new insurance was no longer accepted by the doctor who had seen him since birth. The foster parent chose a new doctor who did not have Daniel's medical history. No attempts were made to collect a complete medical record and the new doctor was unaware that Daniel had been once monitored more closely for a minor heart condition.

history is then compounded by the traumas of the maltreatment that bring children directly into foster care, and the subsequent losses they experience as a result of being removed from their families, and often from their communities, schools and friends. Consequently, children and youth in the foster care system across the country experience poorer health and often have unmet health care needs including undiagnosed or under-treated medical conditions. As in all states, children in Delaware's foster care system are a particularly vulnerable population with significant and unique health care needs.

Upon entry into Delaware's foster care system, children and youth in foster care are categorically eligible for Medicaid and enrolled in managed care. They have the same health services available to them as other Medicaid eligible children. The only service enhancements for these children consist of availability of a general health screening and behavioral health screening services accessible on entry into foster care. Findings from the analysis provided to the Task Force indicate that children in the state's foster care system have considerably higher average medical claims than other children and youth enrolled in Delaware Medicaid¹. There are many factors that contribute to these higher claims². For very young children, many have sustained life threatening injuries or are otherwise medically fragile—conditions that typically require higher rates of inpatient hospitalization or urgent and emergency care. Similar to other states' findings, Delaware children six years and older utilize behavioral health services at significantly higher rates compared to other children in Medicaid. For all children and youth in foster care, it is evident that their complex health needs create immediate requirements for comprehensive and coordinated services to improve their outcomes, both in the short term and throughout their lives³.

The Task Force has provided recommendations across four main domains to improve access and quality of care and decrease costs. These domains are screening, care coordination, access to care, and data monitoring and continuous improvement. Following are the recommendations and rationales for each.

¹ Center for Community Research and Service, University of Delaware, Report to the Delaware Task Force on the Health of Children in Foster Care, 2015 (heretofore referred to as the "CCRS Foster Care Report").

² Center for Healthcare Strategies, Inc. Examining Children's Behavioral Health Service Utilization and Expenditures. <http://www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/>

³ Center for Health Care Strategies, Inc. Intensive Care Coordination Using High Quality Wraparound for Children with Serious Behavioral Health Needs. <http://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf>

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SCREENING

Vulnerable populations with identified health risks need to be screened in a timely and comprehensive manner. Currently the Division of Family Services (DFS), private foster care services and Medicaid's Managed Care Organizations (MCOs) use different thresholds regarding timely access to initial and ongoing medical care. State policy currently recommends all children obtain a screening visit including specific requirements for comprehensive care within 5 days if possible or at least within 30 days upon entry into the foster care system.

Vulnerable populations with identified health risks need to be screened in a timely and comprehensive manner. Based on data, only 31% of children new to foster care had a well visit within 30 days of entry to care.

Contracted foster agencies currently require children under their care to have a health screening within 72 hours of entry into care. Based on Delaware data⁴, among children who entered into foster care in Fiscal Year 2014 and who also had a Medicaid claim in Fiscal Year 2013, the percentage of children who had a health screening visit increased from 36% to 72%. However, only 31% of children in foster care had a screening visit within 30 days of entry to care⁵, and after six months in care, only 59% of the children had obtained a screening visit.

The Task Force recommends improving the screening process through the following steps:

1. DFS, in collaboration with health providers, the Division of Medicaid and Medical Assistance (DMMA) and the Medicaid MCOs should align policies and procedures to ensure timely screening of all children in care in accordance with best practice guidelines by:
 - Creating a flow chart of the screening processes that includes the respective roles and communication requirements of each provider, caseworker, foster parent, and birth parent(s) (as appropriate) involved in care of the child.
 - Providing standardized communication of the screening process and the results of all screenings to the primary care provider, caseworker, foster parent and birth parent(s) (as appropriate).
 - Using the comprehensive screening results to provide a risk stratification approach for the implementation of a clear, individualized service delivery strategy for the child.
2. Medical screening should be linked to the behavioral health screening conducted by DFS to ensure that the comprehensive needs of the child are addressed in a congruent and well-integrated way. Methods in which to improve integration of efforts by the DFS Screening and Consultation Unit with the Nemours screening team and other primary care providers should be developed.
3. Nemours and other health providers, in conjunction with the MCOs should explore how to validate, scale, and spread the comprehensive screening provided through the current Foster Care Health

⁴ CCRS Foster Care Report

⁵ This data does not include well visits performed in wellness centers or while a child is in detention within YRS as those data are not included in Medicaid claims. On further review of data without children placed in YRS, the percentage of children screened is still low.

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Program Pilot at Nemours A. I. duPont Hospital for Children, especially in the southern area of the state. The pilot provides a multi-disciplinary approach to ensuring comprehensive screening and initial care planning. This clinic was developed and staffed by physicians at the hospital with a special interest in foster care and supported by the hospital. Currently, about half of the children and youth entering foster care are screened through Foster Care Health Program and many continue to use this clinic as their medical home. Others receive care through community providers whose care is informed by the comprehensive initial screening. All children entering foster care would benefit from this comprehensive approach to screening, but the logistics for case workers and foster parents located downstate create barriers to full utilization of the clinic. Sustaining the current clinic, as well as exploring its potential expansion, would need to include reimbursement considerations for multi-disciplinary comprehensive screenings, coordination of care, and linkages to other providers.

4. DFS, in collaboration with health providers, should develop and implement a protocol that proactively informs providers of the unique needs of children in foster care and the challenges in serving them in order to more directly advocate for a comprehensive approach to meeting the special needs of these children. This protocol may include a form that accompanies a child to health care visits that provides information regarding known medical conditions, explains when

Children in foster care have complex medical needs. There is a need for health expertise within the child welfare system in order to appropriately navigate and respond to the health care needs of children in foster care.

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CARE COORDINATION

Children in foster care have complex medical needs. Within Delaware's foster care system approximately 61% of children in care present to a medical facility for care related to a behavioral health problem⁶. Mental illnesses rarely occur in isolation, and often are accompanied by other general or chronic health needs, as well as educational, environmental or social service needs. In addition, at least 10% of foster care children have asthma, a rate similar to that of other Medicaid children, which can result in increased emergency care use, hospitalization, and cost if the guardian is not educated about medications and asthma management. Care coordination services have proven effective in improving the quality of care while decreasing costs and are the standard of care in many settings across the nation^{7,8}. Additionally, the Child Protection Accountability Commission's (CPAC) and Child Death, Near Death and Stillbirth Commission's (CDNDSC) Joint Foster Care Medical Committee Report⁹, based on a

⁶ CCRS Foster Care Report

⁷ Institute for Healthcare Improvement. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs.

⁸ Centers for Medicare and Medicaid Services. Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children & Adolescents. <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPST-D-Care-Coordination-Strategy-Guide.pdf>

⁹ Child Protection Accountability Commission (CPAC) and Child Death, Near Death and Stillbirth Commission (CDNDSC). Joint Foster Care Medical Committee Report. <http://courts.delaware.gov/childadvocate/docs/FinalCPAC-CDNDSC-Joint-FC-Medical-Committee-Report.pdf>

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small chart review, suggests the need for health expertise within the child welfare system in order to appropriately navigate and respond to the health care needs of children in foster care. Care coordination is defined by the Agency for Healthcare Research and Quality (AHRQ) as *“the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of healthcare services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care”*¹⁰.

The Task Force recommends taking the following steps to improve care coordination:

1. Develop the capacity for an individual with advanced medical expertise to provide direction on policy and procedures and to direct care coordination and system linkages to improve health outcomes for children in foster care. Best practice models from other states develop expertise in a leadership role within the child welfare agency at a senior administrative level such as a medical director or nurse supervisor. In such models, this position then provides oversight to nurses located in regional offices of the child welfare agency. Based on experiences in other jurisdictions, nursing administrative case management could be accomplished with a staffing ratio in the range of 50:1 or 100:1, as appropriate to the intensity of need.
2. Clarify explicit care coordination roles for MCOs and DMMA, develop communication materials and disseminate these materials to primary care providers and other stakeholders across the foster care system; and ensure these roles are updated and kept current as other changes occur in the health care delivery system.
3. Educate families, caseworkers and providers regarding basic and special health care needs of children in foster care, consent procedures and best practices for care coordination.
4. Support the utilization of resources in order to coordinate care and improve communication and collaboration between behavioral health and primary care. This is recommended because of the higher utilization of psychotropic medications and consequent higher prescriptions costs. In addition, DFS should continue pursuing opportunities to develop a psychotropic monitoring program with recommendations and technical assistance provided by consultants from the Tufts University School

Gwen is a 16 year adolescent who entered foster care when her family was unable to care for her— her birth mother was deceased and her birth father had been diagnosed with cancer. Gwen had a history of depression, aggressive behavior, running away and not attending school. Over the course of one year Gwen was not able to attend school due to severe depression. Over this year, five professionals in three different offices and her school participated in her care – from primary care physicians, to social workers, state crisis specialists, psychotherapy specialists, and psychiatrists. Gwen did not receive psychiatric services because of challenges reaching her birthfather for consent. Gwen received homebound educational instruction for six months until she was able to return to school.

¹⁰ McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C, Brustrom J, Malcolm E, Rohn, L. and Davies, S. (2014) Care Coordination Atlas Version 4 (Prepared by Stanford University under subcontract to American Institutes for Research on Contract No. HHS290-2010-000051). AHRQ Publication No. 14-0037- EF. Rockville, MD: Agency for Healthcare Research and Quality.

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of Medicine and the Casey Family Programs. Processes should encourage and monitor engagement in appropriate evidence-based therapy within the spectrum of behavioral health care.

ACCESS TO CARE

Data indicate significant challenges regarding continuity of insurance coverage for children in foster care¹¹. Among a cohort of 222 children entering foster care in Fiscal Year 2014, 95 children (43%) did

Children and youth in the foster care system across the country experience poorer health and often have unmet health care needs including undiagnosed or under-treated medical conditions.

not have Medicaid coverage in the year prior to entry into foster care. Similar disruptions occur on exit from care. Among children in foster care with a Medicaid claim in Fiscal Year 2013, 23% did not have a Medicaid claim in Fiscal Year 2014. A significant number of children experience a change in insurance upon entry or exit from care; therefore,

processes should be aligned to support access to care and continuity of care for the child whenever possible.

The Task Force makes the following recommendations to support access to care:

1. A sense of urgency regarding health needs should be instilled in stakeholders working with foster children. This vulnerable population often has immediate, as well as probable health needs. Urgency should include immediate enrollment in Medicaid, with special provisions to include timely access to needed services. The process for accessing services should be clarified and communicated to providers and other stakeholders. Currently confusion exists about whether there is a gap in service coverage between the time of enrollment into an MCO and the effective date for when coverage actually begins. There is also a lack of understanding of other payment processes that may apply during this transition.
2. DFS should provide information and training to the MCOs on the respective roles and responsibilities of caseworkers, foster parents and birth parents in accessing and monitoring a child's care. The MCOs should also provide information and training to help caseworkers and foster parents on how to navigate the health care system by clarifying how to connect to care and resolve concerns. For many users the health care system is complicated, fragmented, and consequently, can be difficult to navigate. These challenges can be intensified for children in foster care who have complex health needs. Training for both the MCOs and caregivers would help to relieve some of the confusion.
3. The MCOs and DFS should develop policies and procedures to resolve urgent health needs of foster care children, including designated points of contact.

¹¹ CCRS Foster Care Report

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4. DFS and DMMA are encouraged to explore the benefits and risks of consolidating all children in foster care under one MCO given the need to support improved communication, data sharing and coordination of care. Current enrollments of children in foster care in Medicaid MCOs indicate that approximately 50 children or youth are enrolled in one MCO, while approximately 600 children or youth are enrolled in another MCO. Such consolidation could better afford a mapping of providers to locations of foster care homes, streamline data sharing and monitoring, and enhance coordination of care.

A sense of urgency regarding health needs should be instilled in stakeholders working with foster children.

5. DFS and health providers serving children and youth in foster care should be included in the Delaware State Innovation Models (SIM) Initiative in order to leverage these efforts to improve health outcomes for this vulnerable population of children.

6. DFS and DMMA should work with the MCOs to ensure a smooth transition of insurance coverage and continuity of care when children exit the foster care system, since most children exiting foster care are to be reunified with their birth families.

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DATA MONITORING AND CONTINUOUS IMPROVEMENT

The receipt of timely, accurate and complete data is integral to further understanding the challenging and unique health care needs of the foster care population. The current fragmentation of data makes it difficult to obtain an accurate picture of health for children in foster care. Not all health providers use or have access to the same Electronic Medical Records (EMR) systems, or primary care providers use a variety of EMR systems. For foster care youth connected to juvenile justice services delivered by the Division of Youth Rehabilitative Services (DYRS), health information is based primarily on paper charts and care provided under a contract with Christiana Care Health System has a unique EMR system. Similarly, intensive level behavioral health services provided by the Division of Prevention and Behavioral Health Services or its contract providers are recorded on different data platforms.

The Task Force makes the following recommendations to use data to drive continuous improvement of the health care of foster children:

1. Collaborate with the Center for Community Research and Service at the University of Delaware to collect outstanding, baseline Medicaid data.
2. Collect preventive dental claims. While the Center for Community Research is a repository of Medicaid health claims data, that data set includes only a portion of more extensive dental claims. Preventative dental claims are not in this data set, but this data is important to assessing the dental health needs of children in foster care and should be provided by DMMA to DFS regularly for analysis.

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3. Provide ongoing data analysis at the provider and systems levels and determine the MCOs' role in this process.

Provider

- Facilitate further linkages to the EMR across providers statewide.
- Explore quality improvement processes that will help primary care providers in real time track and meet the individual health needs of children in state custody.

Systems

- Create or leverage an existing interagency group (e.g., MCOs, Division of Public Health, Department of Education, Department of Services for Children, Youth and Their Families) to review data, connect to the Delaware State Innovation Models (SIM) Initiative work or explore other novel ways to address screening, care coordination and access issues.
- Develop a common dashboard for regularly monitoring and analyzing performance and progress against targeted outcomes such as well child visits, health screenings performed upon entry into the system, and use of psychotropic medications.

DELAWARE TASK FORCE ON THE HEALTH OF CHILDREN IN FOSTER CARE MEMBERS

Vicky Kelly, Co-Chair, Delaware Division of Family Services; Catherine Zorc, Co-Chair, Nemours; Heather Alford, Delaware Division of Family Services; Janice Barlow, Delaware Kids Count; John Bates, Delaware Division of Family Services; Kitara Bingham, Life Lines Program, West End Neighborhood House; Dick Christopher, Nemours; Diane DiSabatino, Christiana Care Health Systems; Mary Lou Edgar, A Better Chance for Our Children; Kelly Ensslin, Delaware Office of Child Advocates; Patricia Gordon, Delaware Department of Public Health; Caroline Jones, Kind for Kids; Cindy Knapp, Children's Choice; Cha-Tanya Lankford, Pressly Ridge; Carolyn Morgan, Progressive Life; Sue Murray, Delaware Division of Family Services; Leslie Newman, Children & Families First; Anne Pedrick, Child Death, Near Death, and Stillborn Commission; Pat Redmond, Nemours; Kimberly Reinagel-Nietubicz, Representative Melanie George Smith's Office; Amy Renwick, Nemours; Margot Waitz, Christiana Care Health Systems; and, Krishna White, Nemours.

Advisory Sub-committee: Diane Abatemarco, Nemours; Norma Everett, Nemours; Alisa Haushalter, Nemours; Kristen Maiden, Nemours; Mary Kate Mouser, Nemours, and Mollie Poland, Nemours.

Administrative Assistant: Monica Pyewell, Nemours.

UNIVERSITY OF DELAWARE CENTER FOR COMMUNITY RESEARCH & SERVICE RESEARCH TEAM

Erin K. Knight, Mary Joan McDuffie, Katie Gifford, Steven W. Peuquet, Victor Rendon, Gemma Tierney, and Caprice Torrance

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