Key Findings from Participation in a CMS Affinity Group on Health Care for Children Entering Foster Care (June 2024)

Background

The American Academy of Pediatrics classifies children in foster care as having special health care needs. AAP Guidelines (Policy Statement, Technical Report) for caring for children in foster/kinship care include the following:

- An initial health screening visit within 72 hours of entering custody.
- A comprehensive health assessment within 30 days of entering custody. This includes assessment of medical, mental health and dental health needs with appropriate referrals and development of an individualized care plan.
- An enhanced (more frequent) well visit schedule

Vermont was selected to take part in a **CMS Affinity Group "Improving Timely Healthcare for Children and Youth in Foster Care,"** which ran from August 2021 through August 2023, and focused on the comprehensive health assessment. The VT team consisted of representatives from the Department of Vermont Health Access (DVHA), Family Services Division of the Department for Children and Families (DCF), Division of Family Child Health (FCH, formerly Maternal Child Health) of the Vermont Department of Health (VDH), and the Vermont Child Health Improvement Program (VCHIP). The Vermont team and ten other state teams met together remotely every month and engaged in monthly individualized quality improvement coaching sessions. Vermont selected an aim of increasing by 10% the number of children and youth receiving a comprehensive health assessment within 30 days of entering custody. This report summarizes the work VT accomplished as part of this Affinity Group, as well as recommendations for future work to provide shared learning for partners working in this space, including FCH, DCF, DVHA and the Vermont AAP.

VT system for notifying medical homes of patient custody status and prior work

In the early 2000's, a memorandum of understanding (MOU) between DCF and the VDH/division of FCH was established. This MOU identified a nurse based at each of the 12 local VDH district offices who would obtain health information on each child entering custody in a timely manner and share that information in the form of a Health Information Questionnaire (HIQ) with DCF. The MOU permits DCF to notify the FCH nurses within 3 business days when a child enters foster care in their district. A release is provided that authorizes the FCH nurse to communicate with the child's medical home. If the medical home is unknown, the nurse can determine the most likely medical home using Medicaid claims and/or the immunization registry. The FCH nurse often sends an HIQ to the medical home to gather the most up-to-date medical and dental information. The HIQ is entered into FSDNet, DCF's electronic record, within 30 days. If the child has any immediate health needs, or scheduled appointments, the FCH Nurse provides this information to the DCF Family Services Worker directly.

Prior to working with the Affinity Group, VCHIP engaged in a project with DCF and VDH's FCH division in 2020 to assess processes, successes, and opportunities for improvement for medical care as children enter foster care. As part of this work, VCHIP interviewed FCH nurses, DCF district administrative assistants, medical providers, and foster parents to determine current processes.

FCH nurses in each VDH district and almost all DCF district administrative assistants were interviewed to assess how the FCH nurse was notified when a child enters custody, and how the FCH nurse interacted with medical homes to gather information needed to complete the HIQ for each child entering custody. VCHIP learned there was great variability among the DCF districts and FCH nurses. There were different workflows and expectations, different mechanisms for notifying the FCH nurse when a child came into custody, and different levels of FCH nurse interaction with the medical home. Some DCF offices provided timely notification when children entered foster care, while others did not. Some FCH nurses worked closely with medical homes, some only interacted with the medical records department to obtain information. Some FCH nurses interacted with foster parents directly to answer medical questions and facilitate appointments with the medical home, and some did not. Most FCH nurses were interested in clarification about role expectations and scope of their work.

Fourteen medical providers across the state were interviewed about their patients entering foster care (with collaboration from Dr. James Metz and two pediatric residents). VCHIP learned that most (11) of the providers were not aware when their patients entered DCF custody. Most (12) were not aware of the AAP guidelines or did not have protocols in place to follow the guidelines, and the length of time until children were seen after entering foster care was variable, especially for adolescents. Providers were rarely informed of the reason for custody and felt that information was essential to being able to provide appropriate care for the child. However, all providers felt responsible for these patients, and felt that these patients should remain in their medical homes whenever possible.

VCHIP met with the Foster Parent Workgroup and conducted a focus group of 5 foster parents to determine what they saw as the major medical issues for children entering foster care. Many of the foster parents were not informed about the medical home as a child entered custody. Medications were not always provided, and when they were, information about the correct dosing, reason for giving, and potential side effects were not always available. Refills of missing medications were often difficult to obtain. Many experienced difficulties making an initial medical appointment for a child, reporting that they were often told by the front desk staff that the child already had a health supervision visit and did not need to be seen. Most foster parents said there was great benefit in having access to the child's Electronic Health Record. Foster parents noted not all providers recognize and/or understand the purpose of the medical authorization form and that office visits with the medical provider are needed for foster parents to get all important information to care for the child and their medical needs.

Prior to beginning the CMS Affinity Group work, **VCHIP engaged two large pediatric practices** outside of Chittenden County in quality improvement to increase the number of children entering foster care who had a comprehensive health assessment within 30 days. Initial barriers included a lack of awareness of the AAP guidelines for initial care of children entering custody, and lack of office systems to notify the pediatric provider and to reach out to the foster parent to schedule a comprehensive health assessment. Some practices required legal documentation of foster placement before being able to reach out. Some practices found it more efficient to see the child for a health supervision visit but were not always able to schedule that within 30 days due to Medicaid restrictions for payment. Care coordination and the generation of care plans were variable at each practice, as criteria for care coordination differed, and not all providers recognized children in foster care as children with special health care needs. VCHIP learned that timely notification by DCF and the FCH nurse typically led to more children seen for a comprehensive health assessment. Direct communication with an identified point person(s) at the practice (often a care coordinator) was important to the process, and often led to

timely outreach to foster parents to help with immediate medical issues. Adolescents were less likely to receive timely care in the medical home. Change of placement and residential placements could be the reason for this. Lack of notification of change of placement also led to missed appointments.

Affinity Group Activities

When the CMS Affinity Group began, the VT Team already had some clear ideas of what needed to be done. The VT team began by **assessing available data** to determine the baseline of children entering foster care who received a comprehensive assessment within 30 days. Identifying VT children entering foster care proved to be a challenge, as the flagging system in Medicaid is complicated, and not efficient. To track children and youth entering foster care, DCF provided a file to DVHA so they could match the child in Medicaid. Some children were not able to be matched so the data is incomplete. Once identified, Medicaid claims data was utilized. Since there is no CPT code for a comprehensive health assessment for children entering custody, a proxy was determined. Claims data analyzed included E&M CPT codes for office visits lasting 30 minutes or longer and well visit codes by primary care providers. The data analyzed included children who entered custody during the calendar year period and were enrolled in Medicaid for 30 or more days following the date of custody entry. Infants in the NICU were included in the denominator, although they could not have had any office visits. Data was stratified by child age for the years 2019, 2020 and 2021. See appendix A for baseline data results. Note that the COVID pandemic resulted in lower numbers of children entering foster care in VT.

Using QI frameworks and a key driver diagram, drivers were identified (see appendix B). One identified barrier to following recommendations by the AAP for comprehensive assessments and an enhanced visit schedule was Medicaid payment. VT Medicaid allows for only one well-visit per year for children aged 3 and older. The Affinity Group was able to work with DVHA to have additional well visits and screening covered, in alignment with AAP guidelines, when the code Z 62.21 (child in foster care) is used. A coding guide was created: “Billing for Services: Children/Youth in Foster Care” (see appendix C).

The Vermont team identified a DCF district that was interested in engaging with community practices. Process flow mapping was completed with DCF district leadership, the administrative lead and the FCH nurse to identify steps in the practice notification process when a child enters foster care. This mapping revealed opportunities to test strategies that could improve the process. The district designed a **joint letter** from DCF and the FCH nurse to be sent to practices when a patient entered foster care. This letter included the foster parent and Family Services Worker (FSW) contact information (see appendix D), caregiver authorization form (see appendix E), release of information to interact with the FCH nurse (see appendix F), AAP recommendations (see appendix G) and the coding and billing guide. This letter is a call to action for the practice to contact the foster parent and schedule an appointment, and contains the information needed to legally do so. Results of the tests of change showed that early notification and contact with the foster parent often led to scheduling the comprehensive health assessments within 30 days. Barriers to the assessment included youth changing placement and entering residential care. Some family medicine practices did not respond to the letter. The strategy of sending this joint letter to practices has been spread to two additional DCF districts.

Lessons learned from other states in the CMS Affinity Group

Some states in the CMS Affinity Group with large numbers of children entering foster care in a defined region, such as a large city, utilized regional foster care clinics where all children entering foster care

were immediately referred for the comprehensive health assessment, and often for ongoing care. They utilized either state agencies or nurse care coordinators for HMOs to provide care coordination for children in foster care.

Other states with smaller numbers of children entering foster care, often spread over a wider geographic region, relied on existing medical homes to provide care. Several states designated care coordinators, employed by the state or managed care organizations, to assist in coordinating initial health visits, as well as ongoing care. For example, South Carolina implemented a Health Quality Improvement Coordinator to ensure appointments were scheduled, foster parent/caregivers were contacted, and comprehensive health assessments were completed. Assessment rates improved to over 80%. Hawaii improved communication between Child Welfare Services and the managed care organization (MCO) when children enter custody. The MCO now coordinates access to comprehensive health visits within 45 days. They had nearly 100% success utilizing this strategy. Michigan had success when the Health Liaison Officer, employed by the Department of Health and Human Services, verified that the initial medical exam is scheduled by the foster parent within 2 business days of the child's placement into foster care, and ensured the Comprehensive Health Assessment had been scheduled within 5 days of the child's placement into foster care. Timely medical visits increased to 88% in 4 counties.

Proposed Plan for Vermont

As a result of the CMS Affinity Group, VT has identified the following steps to spread success to all districts in VT:

- Structure communication between the DCF district administrative person and the FCH nurse. Meet at least every 6 months, ideally more often to fine tune the communication.
- Send the joint letter from DCF and the FCH nurse to the appropriate medical home within 3 business days of a child entering custody, ideally as soon as possible.
- Send the letter to a point person designated by the practice, usually a care coordinator, who can contact the foster parent as soon as possible to answer medical questions and facilitate scheduling the appointment for the comprehensive health assessment with the appropriate medical provider, ideally within 30 days, and coordinate any specialty care needed.
- Be in touch with the medical homes in the district before the process begins, so they will be aware of the AAP guidelines, and can choose a point person for their practice.
- Follow data to determine success and pinpoint gaps.

Lessons learned from activity to date

- Pediatric practices VCHIP contacted want to care for their patients in foster care, but not all were familiar with the AAP guidelines.
- Patients from a particular practice enter foster care intermittently, so establishing a consistent workflow can be challenging.

- Youth are receiving lower rates of comprehensive health assessments than younger children, which can be due in part to more frequent change of placements including residential placements.
- Failure to notify medical homes of foster care placement changes can result in children missing needed medical care.
- Confidentiality of court proceedings can impact information shared with medical providers.
- The system is fragile. The process is often dependent upon one individual at each site (DCF administrative assistant, FCH nurse, practice point person), and redundancies are not built into the system.

Next Steps/Considerations

- Prioritize healthcare for children in foster care along with child safety. Same-day notification of the medical home when a child enters custody, along with timely notification of placement change, would ensure the best medical care for children entering foster care. (DCF)
- Continue working with medical homes, including family medicine practices, across the state to facilitate usage of the AAP guidelines (comprehensive health assessment, care coordination, enhanced health care visit schedule). (VCHIP)
- Develop more robust care coordination for children in foster care (including usage of shared plans of care) to ensure consistent medical care. Care coordination by DCF or managed care organizations has shown to be effective in other states for children entering custody. (primary care providers)
- Clarify the role of the FCH nurse across districts. Additional time or personnel may be necessary, especially in some of the larger districts. (FCH)
- Investigate why youth in foster care have significantly lower rates of comprehensive health assessments in medical homes compared with younger age groups. (VCHIP in collaboration with DCF and FCH)
- Track health, dental health, and mental health outcome data for children and youth in foster care. Process improvement with the Medicaid flagging system used when children enter custody could assist in identification of foster children within claims. (VCHIP in collaboration with DVHA, DCF, FCH)

Appendix A

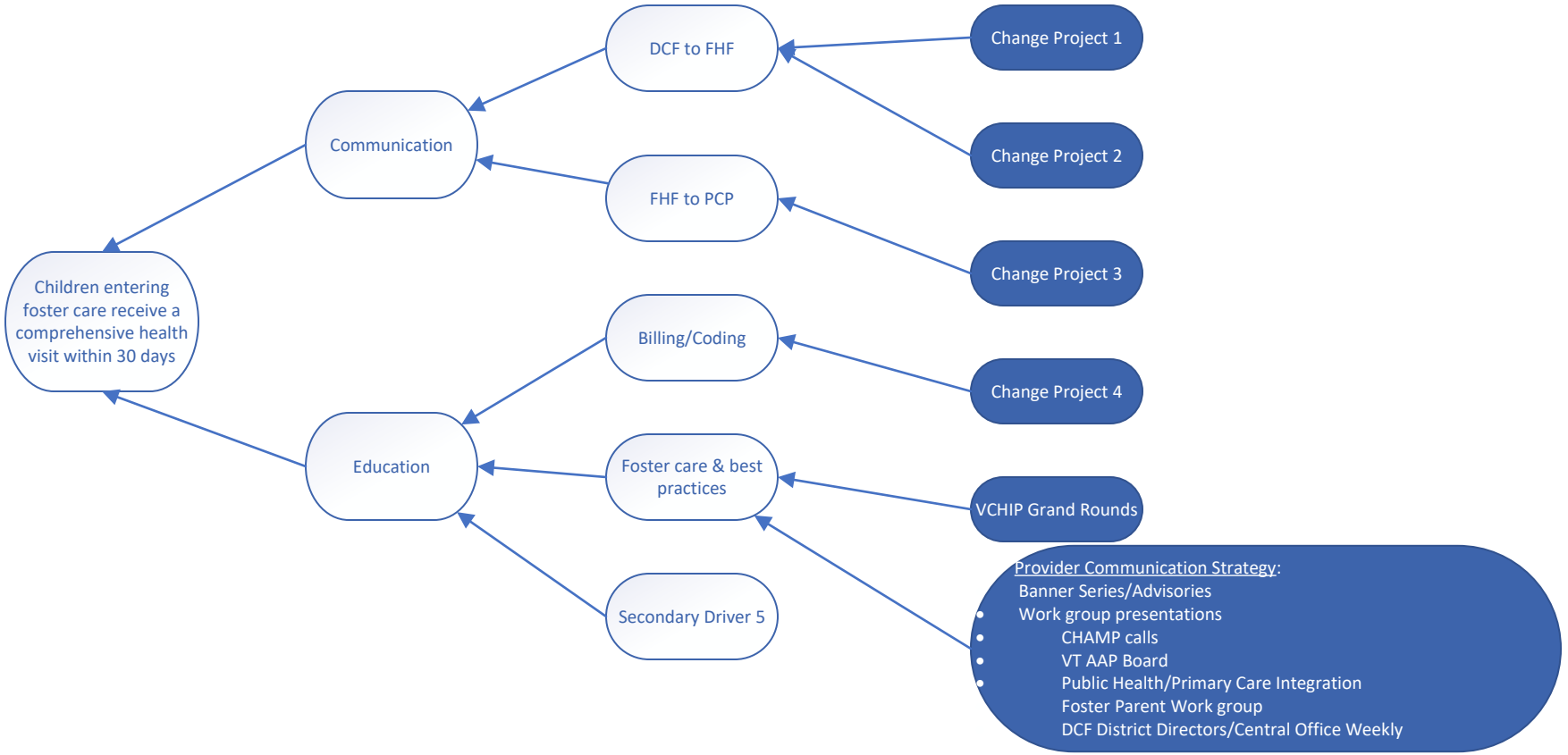
Comprehensive Assessment Data

	2019			2020			2021		
Classification	Number of Children	Comprehensive Assessment (0-30 days)	Any Visit (0-30 days)	Number of Children	Comprehensive Assessment (0-30 days)	Any Visit (0-30 days)	Number of Children	Comprehensive Assessment (0-30 days)	Any Visit (0-30 days)
Infant (0-1)	**113**	**73%**	**81%**	**91**	**80%**	**85%**	**63**	**75%**	**79%**
Young Childhood (1-4)	**179**	**39%**	**53%**	**108**	**44%**	**55%**	**121**	**46%**	**62%**
Late Childhood (5-11)	**197**	**25%**	**37%**	**159**	**25%**	**31%**	**167**	**40%**	**50%**
Adolescent (12-17)	**230**	**21%**	**30%**	**166**	**16%**	**20%**	**153**	**31%**	**35%**
Eighteen and Older	**0**			**0**			**12**	**17%**	**25%**
All Districts Total	**719**	**35%**	**45%**	**524**	**36%**	**42%**	**516**	**42%**	**52%**

Medicaid claims data was utilized and a proxy for the comprehensive visit type was selected. A proxy needed to be used as there is no code for the visit type. Claims data analyzed included E& M CPT codes for visits lasting 30 minutes or longer and well visit codes in a primary care setting. Any visit is from claims data utilizing any CPT codes within range of 99201 to 99499 in a primary care setting. The data analyzed included children who entered custody during the calendar year period and were enrolled in Medicaid for 30 or more days following the date of custody entry. Infants in the NICU who did not see a medical provider in primary care were included in the denominator.

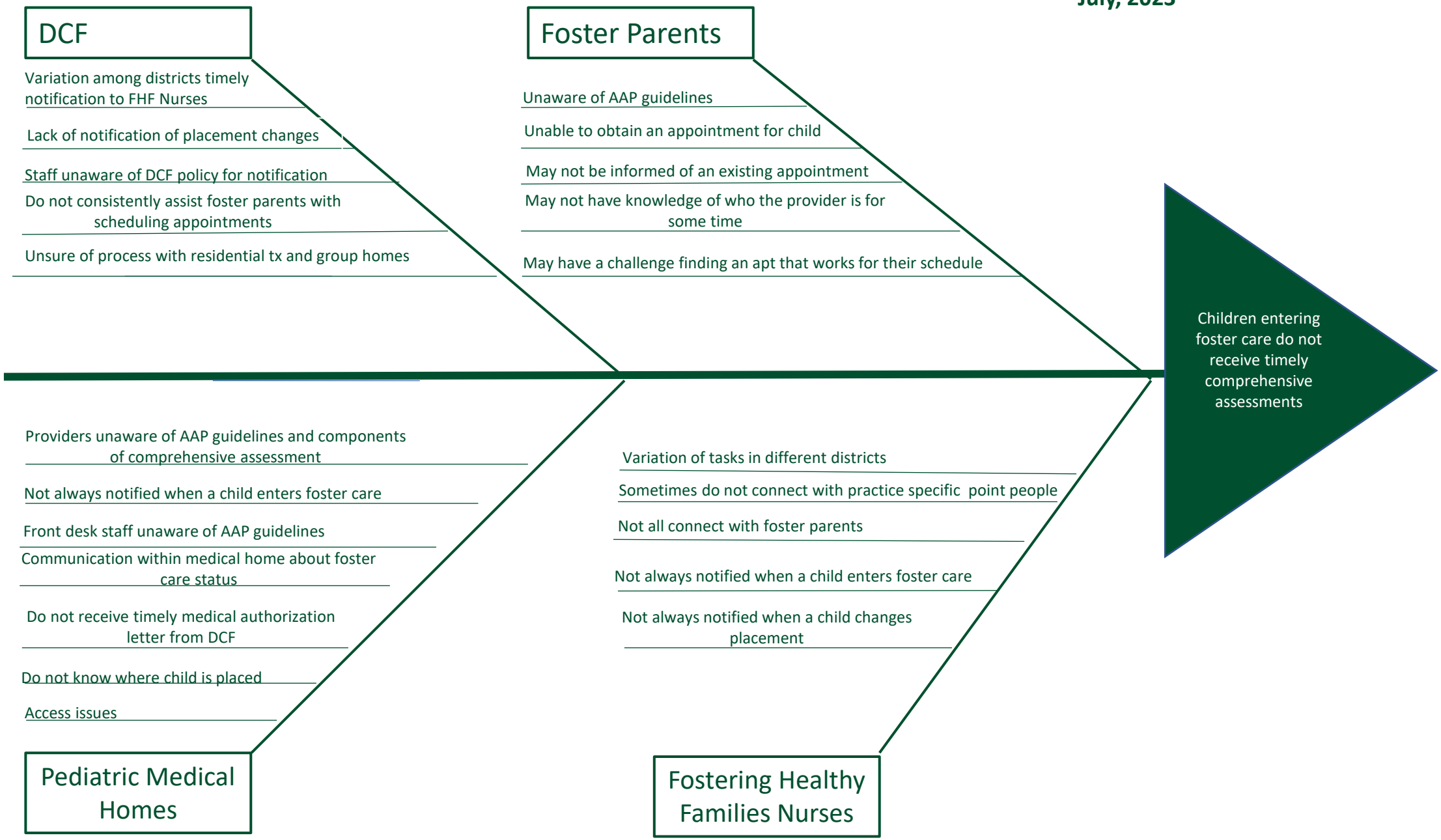
Appendix B1

Foster Care Learning Collaborative Driver Diagram



Appendix B2

Barriers to Timely Comprehensive Assessments in Medical Homes
July, 2023



VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Vermont Medicaid

Billing for Services: Children/Youth in Foster Care*

New Patient	Established Patient

These code sets are designed for evaluation & management of the child to address specific issues/concerns as needed. Code according to medical decision making (MDM) or time.

Problem-Focused Visits

99203	30-44 min
99204	45-49 min
99205	60-75 min

Problem-Focused Visits

99213	15-24 min
99214	25-39 min
99215	40-54 min

These code sets are designed for the periodic evaluation & management that is reflective of the age of the child.

Periodic Preventative Visits 99381-99385

Periodic Preventative Visits 99391-99395

Other evaluation & management codes may be used as appropriate for the services provided and the scope of practice of the healthcare provider.

These services may include counseling, risk factor reduction, behavior change intervention, as well as chronic care management.

Screenings & Assessments

96110 - Developmental screening (eg, developmental milestone survey, speech and language delay screen)

96127 - Brief emotional/behavioral assessment (eg, depression inventory, ADHD scale)

96160 - Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal)

Other screening or assessment codes may be used as appropriate. Include scoring and documentation for each standardized instrument used.

Modifiers & Diagnosis Codes

The use of modifiers may be necessary to indicate that the services are indeed separate, and both were performed.

Z62.21 – Child in welfare custody*

May use this code as a secondary diagnosis for ALL encounters.

For questions, please contact your Gainwell Representative

Utilize the most appropriate and detailed diagnosis code. Refer to the ICD-10 DX code set and the AAP Coding Fact Sheet for Treating Trauma.

VERMONT

Department of Health
Division of Family and Child Health
Street Address
City, State, Zip Code
www.healthvermont.gov

Department for Children and Families
Family Services Division
Street Address
City, State, Zip Code
https://dcf.vermont.gov/fsd

FOSTER CARE PLACEMENT NOTIFICATION

Date

To Whom it May Concern:

Child's Name (DOB: XX/XX/XXXX) is in the legal custody of the Commissioner of the Vermont Department for Children and Families (DCF) as of Date of Custody. Relevant contact information for the child's placement, Family Services Division staff, and other contacts are listed below.

	Name	Phone/Email
Foster Placement (Caregiver or Program)		
Family Services Worker (FSW)		
Family Services Supervisor		
XXXXX District Office (XDO)	**(XXX) XXX-XXXX**	
Vermont Centralized Intake & Emergency Services (CIES)	**1-800-649-5285**	

Medical Provider: Please contact the foster/kinship family as soon as possible to schedule a comprehensive health exam appointment. The child/youth should be seen within 30 days of entering DCF custody. Children with recent injuries or complex health needs may require an appointment more urgently.

Please see the following page for recommendations from the American Academy of Pediatrics (AAP). Please feel free to contact FCHC Name, RN, VDH Public Health Nurse at **(XXX) XXX-XXXX** or **EmailAddress@vermont.gov** with any questions.

Thank you,

FCHC Name, RN
Family and Child Health Division
Vermont Department of Health

FSD District Director Name
Family Services Division
Department for Children and Families

Enclosures:

- Caregiver Authorization Letter
- VCHIP & AAP Summary
- Vermont Medicaid Billing for Services for Children in Foster Care

VERMONT

State of Vermont
Department for Children and Families
Family Services Division

Agency of Human Services

To Whom It May Concern:

_____ is in the legal custody of the Commissioner of the Vermont Department for Children and Families (DCF) and is currently placed in the care of _____.

Permission is hereby given to _____ on the following topics:

- The child's foster parent(s) are permitted to travel within the United States and Canada with the child. Travel to Canada will require the child's birth certificate or passport.
- The child's foster parent(s) are permitted to obtain routine and emergency medical, psychiatric, psychological, dental, ophthalmologic, or other specialized medical services or treatment recommended by a licensed physician. Routine medical care will include immunizations and vaccinations. The Family Services Worker or other district office team member will be notified of medical decisions made with the authority of this letter, and must approve extraordinary medical care (such as specialized tests, anesthesia, surgery, treatment related to serious injuries). Any changes in providers (primary care, therapist, etc.) will be determined by a member of the district office team.
- The child's foster parent(s) may provide permission and sign for the child to participate in childcare/daycare or school outings and field trips, sports, clubs, community events, and extracurricular, enrichment, cultural, and social activities.

The district office telephone number is _____. The after-hours and emergency telephone number is **1-800-649-5285**.

Child/Youth's Name	Medicaid Number	Date of Birth

Respectfully,

On behalf of Chris Winters, DCF Commissioner

Vermont Department of Health
Fostering Healthy Families (FHF) Program
Authorization to Disclose Health Information

Name of Child/Youth: _____ **DOB:** _____

The Department for Children and Families (DCF) is the custodian for _____ who was placed in the care and custody of the Commissioner of the Department for Children and Families (DCF) on _____.

As custodian:

I give my permission for _____, _____ to
Name of Facility *Address*

release the entire medical record pertaining to _____, to
Name of Child/Youth

_____ and/or _____ of the

Department of Health, Fostering Healthy Families Program for the purpose of ensuring that this child/youth receive adequate medical care.

By signing this form, I understand:

- The reason(s) I am being asked to sign this authorization.
- I am signing this authorization voluntarily as the legal representative for this child/youth who is in the care and custody of the Commissioner of the Department for Children and Families (DCF). The child/youth may be denied services under the Fostering Healthy Families (FHF) Program if I choose not to sign this authorization.
- The information released may include alcohol and/or drug treatment records.
- Alcohol and drug treatment records are protected under the federal regulation governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 Parts 160 and 164, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for by the laws.
- While the Vermont Department of Health takes every precaution to protect health information, once it is released pursuant to this authorization, it may be subject to re-disclosure by other parties.
- I may revoke this authorization at any time by contacting _____, RN at the Vermont Department of Health, phone number _____, except to the extent that it has been acted upon.
- If I do not revoke or update this authorization, it will be in effect as long as this child/youth is in the care and custody of the Commissioner of the Department for Children and Families (DCF).
- I will be provided a copy of this form.
- All items on this form and my questions about this form have been answered.

Title: _____ **Relationship to Client**: _____

_____ _____
PRINTED NAME **SIGNATURE**

Legal Representative **Date**

In 2015, the American Academy of Pediatrics published a policy statement and a technical report on Health Care Issues for Children and Adolescents in Foster Care and Kinship Care (Policy Statement; Technical Report). These documents give guidance on recommended timing and content of health care visits for children and youth entering foster care. In 2020, the Vermont Department for Children and Families began aligning their policy with these guidelines in order to promote timely and comprehensive health care for children and adolescents in DCF custody (Policy 77: Medical Care for Children and Youth in DCF Custody). Ideally, this care would take place in the child's already established medical home, where the child or youth may be well-known to the health care provider(s).

Timely communication between the medical home and the foster parent at the time a child or youth enters custody is essential to transmit vital information about medical diagnoses, medications, and pending medical appointments, as well as answer questions the foster parent may have about the child's development and behaviors. The recommended **Initial Health Screening** may look different for various situations, sometimes depending on the circumstances that brought the child into custody.

The **Comprehensive Health Assessment** (recommended to occur within 30 days of entry into custody) should address all areas of child functioning. It is meant to include assessment of physical, mental, and dental health, school performance, and trauma history; lead to appropriate referrals; and result in the development of a written **shared plan of care** that could be given to DCF, foster parents, parents of origin, foster youth, and school personnel as appropriate. A coordinated Care Conference is often a good way to incorporate all the input that is required for such a comprehensive plan of care.

Since all children and youth in foster care are considered **Children with Special Healthcare Needs** by the AAP, it is recommended that these patients be followed-up with an enhanced well visit schedule.

There are resources available to help! VCHIP's Children & Youth Entering Foster Care Team would love to meet briefly with your practice to answer any questions you may have and explore ways we can help your practice.

VCHIP can provide brief technical assistance or ongoing coaching regarding:

- Office systems and processes for patients in foster care
- Questions about coding and billing for these visits
- Elements of a shared plan of care that may be unique to this population
- Ongoing quality improvement for comprehensive assessments for children and youth entering foster care

If you are interested in learning more, please contact the VCHIP Team:

jill.davis@med.uvm.edu

kelli.joyce@med.uvm.edu

AAP RECOMMENDATIONS FOR CHILDREN & YOUTH IN FOSTER CARE & KINSHIP CARE:

INITIAL HEALTH SCREENING (within 72 hours)

- Identify health conditions requiring prompt attention: acute/chronic illness, child abuse/neglect, mental health disturbance, pregnancy
- Identify health conditions important in making placement decisions
- Identify significant behavior issues important in making placement decisions

COMPREHENSIVE HEALTH ASSESSMENT (within 30 days)

- Review available health information
- Identify acute and chronic health conditions
- Identify developmental and mental health conditions
- Trauma assessment
- Develop an individualized treatment plan that can be shared appropriately

Components:

- Review of available health information including trauma history, immunizations
- Complete physical examination, hearing and vision screening
- Child abuse and neglect screen
- Family planning, sexual safety counseling, HIV risk assessment for adolescents
- Developmental screen and referral for evaluation
- Mental health screen and referral for evaluation
- Review of school performance
- Dental screen and referral
- Laboratory studies (Consider testing for HIV infection, hepatitis B and C, and other sexually or vertically transmitted infections, and tuberculosis. Adolescent girls should receive a pregnancy test. Laboratory tests for lead exposure and iron deficiency should be performed in children younger than 6 years or any child with a history of pica or signs of inadequate nutrition)
- Anticipatory guidance

RECOMMENDED FOLLOW-UP

Birth–6 months: Ideal to see monthly, especially if born preterm or has chronic medical problems

6–24 months: Every 3 months

2y –21 y: Ideal to see at least every 6 months to assess behavioral health, developmental, educational needs and monitor adjustment to foster care and visitation. Children with significant issues in any health area may need to be seen more frequently.

Reasons for additional visits for children and adolescents in foster care:

- Foster parent support and education.
- Frequent monitoring for impact of transitions, visitation, and uncertainty, and ongoing adaptation to placement.
- Address emerging problems, especially behavioral, emotional, developmental, and educational.