



Report to the Legislature

Foster Care Health

Chapter 74, Section 13, Laws of 2006

September 2006

Department of Social & Health Services
Children's Administration
Division of Program & Practice Improvement
PO Box 45710
Olympia, WA 98504-5710
(360) 902-7920
Fax: (360) 902-7903

TABLE OF CONTENTS

I.	Introduction	Page 2
II.	Executive Summary	Page 3
III.	Background	Page 6
IV.	Foster Care Health Unit Activities	Page 8
	Appendix A: Glossary	Page 26
	Appendix B: Resources/References	Page 29
	Appendix C: Child Information Form	Page 32
	Appendix D: Memo to Clarify Consent Issues for Children in Foster Care	Page 36
	Appendix E: Sample MMIS Billing Data	Page 39

I. INTRODUCTION

Substitute House Bill 2985 (Chapter 74, Section 13, Laws of 2006), directs the Department of Social and Health Services to establish a Foster Care Health Unit within the Children's Administration in order to provide better coordination between the Children's Administration and the Health and Recovery Services Administration. The unit is responsible for considering targeted improvements to the structure, organization, and coordination of health care available to children in foster care. The unit is to communicate their recommendations to the legislature by September 1, 2006, with particular emphasis on the following:

- a. Creation of an office within the department to consolidate and coordinate physical, dental, and mental health services provided to children who are in the custody of the department;
- b. Alternative payment structures for health care organization;
- c. Improving coordination of health care for children in foster care, including medical, dental, and mental health care;
- d. Improving access to health information available to the Children's Administration for providers of health services for children in foster care, including the use of CHILD Profile as a means to facilitate access to such information
- e. Establishing a medical home for each child placed in foster care to ensure that appropriate, timely, and necessary quality care is available through a coordinated system of care and analyzing how a medical home might be utilized to meet the unique needs of children in foster care.
- f. Examining how existing resources are being utilized to provide health care for foster children and options for improving how the resources are utilized.
Particular interest shall be placed on the following:
 - i. Whether the health care services provided to foster children are evidence-based;
 - ii. Whether resources are duplicative or redundant between agencies or departments in the provision of medical, dental, or mental health services for children; and
 - iii. Identification of where resources are inadequate to meet the routine and necessary medical, dental, and mental health needs of children in foster care
- g. Any other issues related to medical, dental, or mental health care for children in foster care

II. EXECUTIVE SUMMARY

For the purposes of this report, unless otherwise specified, the word “health” is used to refer to issues related to the physical, dental and developmental health of children in foster care. Mental health is considered separately due to the various specific initiatives throughout DSHS.

Over the last 20 years, there has been increased national recognition that children in foster care are at unique risk of poor health. Between 1987 and 2002 experts in the field of foster care health issued several sets of health care guidelines for foster children, including the American Academy of Pediatrics, the Child Welfare League of America, and the New York Chapter of the American Academy of Pediatrics.

The vulnerable health of children in foster care has been described by many sources. The American Academy of Pediatrics (AAP) “Fostering Health” publication (AAP, 2002) notes that children in foster care have a “higher prevalence of physical, developmental, and behavioral health conditions than any other group of children.” Other reports and research have firmly established that children in foster care are among the highest risk population for health problems, significantly higher than other Medicaid eligible children. They are at increased risk of chronic disease, both mental and physical. (See multiple references in Appendix B: Halfon, et al; Simms, et al, and others - for a description of the health status, risks, and utilization of children in foster care).

Research done in preparation for this report included:

- Review of available literature
- Survey of internal stakeholders including social workers, CA medical consultants, Foster Care Public Health Nurses (FCPHN – formerly Passport Nurses)
- Review of 21 scenarios from Regions 1(Spokane), 2(Yakima), and 5(Tacoma)
- Review of the results from the Medicaid Eligibility Quality Control (MEQC) foster parent survey done in 2002 and the 2003 well-child parent focus groups were also reviewed.

Additionally, Dr. Anderson and Dr. Bergman conducted a field visit to Illinois. This research furnished examples of 13 state foster care health systems created to respond to recognized needs and risks. Unfortunately, only three of these states have been able to develop statewide programs. One state, Illinois, is somewhat comparable to Washington demographically and has been able to develop a program that assures primary care through a combination of enhanced reimbursement, recognition of centers of excellence, and special contracting with an administrative service organization and local health jurisdictions to assure care coordination.

Overall, the information gathered indicates that children in foster care still have difficulty accessing the health and mental health services that they need.

Below are the prioritized recommendations which were developed in the course of writing this report.

1. Establish the DSHS Office of Foster Care Health as a permanent unit within the department.

- Establish the Office Foster Care Health Unit created by ESHB 2985 as a permanent unit at HRSA responsible for addressing issues around health and mental health care access and quality for children in foster care.
- The Office of Foster Care Health will develop policy to clearly define the roles of HRSA, CA and the Office of Foster Care Health. Particular emphasis will be placed on HRSA as the responsible administration for the care and coordination of health and mental health care for children in foster care.

Recommendations 2 – 4 and their sub-recommendations will require additional funding in order to implement.

2. Improve the Availability of Medical Information for Staff, Caregivers and Providers

(A separate report has been written by the Department of Health which addresses recommendations to improve access to health information, including expanded use of CHILD Profile.)

- Contract with Local Health Jurisdictions for additional Health Program Assistants who will gather medical information to be shared with caregivers and health and mental health providers.
- HRSA to continue to explore options for direct access by physicians to the Medicaid Billing Data.
- CA should work with DOH to provide access to CHILD Profile immunization data to CHET social workers and case carrying social workers.

3. Improve Coordination of Health Care

- The DSHS Office of Foster Care Health should work to establish at least one “Center of Foster Care Health” as a pilot for a statewide program. The pilot program would initially serve up to 2000 children Possible pilot sites include Sacred Heart in Spokane, the Children’s Village in Yakima, MaryBridge in Tacoma and the Children’s/Odessa Brown Clinic in Seattle. *(Funding for this recommendation was included in the Governor’s Budget.)*
- HRSA will emphasize the diagnosis of developmental disabilities in conjunction with developing criteria for physicians participating in the Centers for Foster Care Health.
- Allow for cash payment in lieu of medical support enforcement through parent’s employer or union.
- Explore the possibility of further maximizing access to health care services for children in foster care by allowing them to subscribe to managed care plans when it is in their best interest.

4. Improve Coordination of Mental Health Care

- CA will contract with qualified mental health professionals to act as mental health liaisons between the mental health system and social workers, clients and caregivers. The Mental Health Liaisons will connect children who do not meet the RSN access-to-care standards with other community mental health resources. *(Funding for this recommendation was included in the Governor's Budget.)*
- DSHS to continue to participate in efforts with the Mental Health Transformation Grant as well as other efforts that address the gaps in mental health services available to children in foster care.

III. BACKGROUND

Over the last 20 years, there has been increased national recognition that children in foster care are at unique risk of poor health. Between 1987 and 2002 experts in the field of foster care health issued several sets of health care guidelines for foster children, including the American Academy of Pediatrics, the Child Welfare League of America, and the New York Chapter of the American Academy of Pediatrics.

Medical experts within Washington State have also recognized that children in foster care have special health care coordination needs. In November 2000, Dr. Abraham Bergman, a University of Washington pediatrician, wrote that the health of children in foster care suffered, not because there was no financing available (all children in foster care are covered by Medicaid), but because the health system was not organized to meet their health needs. Specifically he pointed out the 'disconnect' between child welfare workers who administer foster care, and the staff who administer the state Medicaid program (Bergman 2000).

In April 2001, an initial Washington State effort to bridge this disconnect resulted in several cross-divisional recommendations that included the formation of an inter-agency Foster Care Health workgroup. Representatives to the workgroup included staff from the Department of Health, HRSA, ADSA, and CA. The workgroup continues to meet regularly to address ongoing health issues for children in foster care. Dr. Bergman provides consultation and collaboration to the workgroup around their ongoing efforts.

Workgroup information-gathering efforts included the January 2002 survey of foster parents to examine health care access issues for children in foster care in Washington State, carried out by the Medicaid Eligibility Quality Control unit (MEQC 2002). The survey results indicated that Washington State had to work harder to ensure access to adequate health care for children in foster care. One Hundred Seventy-seven foster families were sampled; almost all were able to identify a primary medical provider. However, 85/177 foster families identified one or more problems getting health care, including difficulties related to obtaining and sharing medical information, receiving the child's Medicaid Identification card in a timely manner, finding a doctor willing to take Medicaid reimbursement, and obtaining mental health care. The results of this survey gave direction to the workgroup for areas needing improvement.

Another source of information to the Foster Care Health Workgroup was an HRSA-sponsored report of parental attitudes towards well-child care which found similar concerns among the 23 foster parents who participated in targeted focus groups. These parents described particular issues with timely access to preventive care, and access to medical information, particularly for children with chronic diseases. They also expressed the wish for a special place where foster children could receive care from knowledgeable providers (Foley 2003).

Based on the results of the surveys and focus groups, the Foster Care Health Initiative Workgroup, completed improvements to the foster care health care system including:

- Automatic disenrollment of foster children from DSHS managed care into the Foster Care fee-for-service medical plan
- Payment rate to qualified providers performing EPSDT examinations for children in out-of-home care was doubled
- Inclusion of children placed by the department into relative care into the foster care fee-for-service medical program
- Creation of a voucher to guarantee payment to medical providers for children who have not yet received their Medicaid ID card
- Hiring of Medical Consultants by the Children's Administration in order to assist social workers in understanding the complex medical needs of children in foster care

The Braam lawsuit settlement of August 2004 also included initiatives to improve health care for Washington State children in foster care.

Under the terms of the Braam Settlement Implementation Plan, the department is required to:

- Develop and implement a plan for children to have initial health screenings within 72 hours of placement
- Assure and document completion of comprehensive physical and mental health screenings within 30 days of placement, using the multi-domain Child Health and Education Tracking process (CHET). This includes a 'well-child' (early periodic screening diagnosis and treatment screening --EPSDT) exam performed by a qualified health professional as well as identification of mental health and substance abuse concerns.
- Obtain a comprehensive mental health assessment for children who are identified with mental health concerns.
- Obtain timely mental health treatment for children assessed as requiring treatment
- Refer children/youth that are identified as having substance abuse issues to the appropriate treatment resources.
- Incorporate results of screenings and assessments into a comprehensive health and education plan.
- Obtain regular and periodic updates to screenings and assessments

Finally, SHB 2985 (Chapter 74, Section 13, Laws of 2006), the impetus behind this report, calls for a comprehensive review of the current system of health care for children in foster care and to recommend systemic improvements.

IV. Foster Care Health Unit Activities

This portion of the report is organized according to the structural language in SHB 2985 “NEW SECTION, Sec. 4”. Each section includes the language from the legislation, any issues identified, discussion and recommendations.

I. Establish a unit within the Children's Administration to address the requirements of SHB 2985

To address this requirement of SHB 2985, Dr. Nancy Anderson from the Health and Recovery Services Administration (HRSA) was assigned to the Children's Administration (CA) from February to April 2006. CA and HRSA used this opportunity to form the “Foster Care Health Unit” responsible for addressing the requirements of SHB 2985 - including development of the report due to the Legislature on September 1, 2006.

II. Issues to be addressed in the report to the Legislature

A. Creation of an office within the department to consolidate and coordinate physical, dental and mental health services for children in the custody of the department.

The SHB 2985 legislation created the Foster Care Health Unit. The unit reviewed and made recommendations for improvement to the current system for health and mental health care for children in foster care. Per SHB 2985, the existence of the Foster Care Health Unit expires on January 1, 2007.

Based on the issues identified through the research, surveys and discussions, conducted in early 2006, there appears to be a strong and clear need for the establishment of a permanent office within the department to coordinate health services for children in foster care and to address foster care health and mental health care issues. Given the health care expertise available through HRSA staff it would be appropriate to house the DSHS Office of Foster Care Health within HRSA. The Office of Foster Care Health will include participation of HRSA eligibility, clinical, program, contract, and authorization staff as well as participation of the CA Well-Being Unit.

CA's Well-Being Unit is responsible for issues regarding physical health (including dental and developmental), education, mental health, screening and assessment, early childhood and substance abuse. The CA Well-Being Unit will work collaboratively with the new Office of Foster Care Health.

Recommendations:

- Establish the Office of Foster Care Health created by ESHB 2985 as a permanent unit at HRSA responsible for addressing issues around health and mental health care access and quality for children in foster care. The unit will officially be called, “The DSHS Office of Foster Care Health”. The permanent membership of the

“office” will consist of representatives from both administrations with ad hoc representatives from other DSHS offices (i.e. Mental Health and Division of Developmental Disabilities) and other state departments (i.e. DOH and Department of Early Learning). The Office of Foster Care Health will have responsibility for:

- ✓ Identifying access-to-care and billing issues and develop workable solutions that will be communicated to CA and HRSA staff, foster parents, clients and stakeholders.
 - ✓ Assisting staff, clients and stakeholders to navigate the CA, HRSA and Medicaid systems.
 - ✓ Consolidating and coordinate initiatives within DSHS to avoid duplication of efforts and services for children in foster care.
 - ✓ Providing department representation to stakeholder workgroups to ensure that the health and mental health concerns for children in foster care are addressed.
 - ✓ Providing training regarding the special health and mental health needs of children in foster care to internal and external partners.
 - ✓ Developing and supporting initiatives that will improve the health and mental health of children in foster care.
 - ✓ Identifying and addressing service gaps in health and mental health services for children in foster care.
- The Office of Foster Care Health will develop policy to clearly define the roles of HRSA, CA and the Office of Foster Care Health. Particular emphasis will be placed on placing HRSA as the responsible administration for the care and coordination of health and mental health care for children in foster care.

B. Alternative payment structures for health care organization

Coordination of Benefits/Third Party Liability

RCW 26.09.105 requires the Division of Child Support (DCS) to enforce health insurance coverage against the non-custodial parent (also called Third Party Liability) on all cases where DSHS is providing services, including TANF, Medicaid, and foster care. The non-custodial parent must provide health insurance for any child named in his or her child support order if coverage is available through that parent’s employer or union. RCW 26.09.105 is strict in the requirements on how health insurance must be provided and does not allow flexibility for a cash alternative payment when health insurance is not available within the parameters stated above, or when the insurance is available to the custodial parent, but not the non-custodial parent.

In addition, the Medicaid program is required to check for the existence of other forms of health care insurance for all clients. For children in foster care, this process complicates the search for medical care. Even when the non-custodial parent obtains insurance coverage it may not truly be “available” to the child as some medical insurance plans are accessible in certain parts of the state but not in others.

It is often difficult or impossible for foster families to know of third party coverage or to access this resource due to geographic and other reasons. Foster parents often rely on their established medical providers who have expertise in managing the more complex medical issues of foster children. Having to find a new provider based on the type of insurance the child has creates particular difficulties for children in foster care, undue burden for their foster parents and significant billing issues that impact health care providers. The number one reason that medical claims for foster children are denied is third party liability. This is especially counterproductive when the department is trying to recruit more of both foster parents and health care providers to work with children in foster care.

The HRSA/CA/ESA-Division of Child Support Cross Administration Workgroup has developed draft legislation to address the limitations stated above. Additionally the workgroup is pursuing the opportunity to use “pay and chase” on a case by case basis as a short term strategy. Under “pay and chase” all provider claims for eligible children would be paid by DSHS and then DSHS would be responsible for pursuing reimbursement from the third party liability coverage. This process would avoid the issue of providers not being paid and therefore denying future treatment and services to foster children.

Benefits of Managed Care for Some Children in Foster Care

There are additional issues with overall coordination of health care for those children in foster care who are unable to access care. These issues are particularly important because of the relatively high prevalence of chronic health conditions among this population of children.

Most children in foster care are categorically excluded from the HRSA managed care to allow maximum flexibility for the mobility of these children as well as consideration to foster parent ability to access appropriate health services for the children placed in their care. Unfortunately, this means that children in foster care do not benefit from the care coordination integrated into managed care.

In general, children in foster care are able to identify a primary care physician. The disenrollment of children in foster care from the Healthy Options – managed care plans, allowed for better access to providers. Foster children do not have to identify a provider who accepts one of the Healthy Options - managed care plans; they are able to seek services from any provider that accepts Washington medical identification cards. This is especially helpful in the more remote areas of the state where managed care plans were not available in some communities.

There are some circumstances where it is more appropriate for a child in foster or relative care to be assigned to a managed care plan instead of the regular fee-for-service foster care medical program. An example of this issue is in the Vancouver area. In this area of the state, almost ALL medical providers are affiliated with a single managed care plan. It is extremely difficult for children in foster care on fee-for-service

medical to find a provider. For this population, it would be helpful if DSHS had the discretion to assign children to a managed care plan when it is in their best interest.

Assigning children to managed care plans could also benefit children with certain chronic diseases such as asthma. Some managed care plans have medical case management available for people diagnosed with chronic diseases. Medical case management would ensure that referrals and follow-up occur for these patients.

Recommendations:

- Allow for cash payment in lieu of medical support enforcement through parent's employer or union.
- Explore the possibility of further maximizing access to health care services for children in foster care by allowing them to subscribe to managed care plans when it is in their best interest.

C. Improving coordination of health care for children in foster care, including medical, dental, and mental health care

Respondents to the internal stakeholder survey perceived broad access and quality issues with respect to obtaining health care for children in foster care. They described particular issues for timeliness and quality of EPSDT screening, orthodontics, dentistry, entry into and continuity within the public mental health system, and specific health care access issues for children in southwest Washington who are not part of HRSA's managed care system.

Health Care

To address some of the issues surrounding appropriate health care for foster children, the Braam Panel has established an outcome in the Braam Settlement Implementation Plan for children to receive an initial health screening within 72 hours of placement. This is also a recommendation of the American Academy of Pediatrics in their *Fostering Health* publication. The OFCH will begin defining the components of the 72 hour screening as well as determining how clinics/physicians will be reimbursed for these exams.

The FCPHN and FCAP Programs are specially funded to assist in the evaluation of complex children and provide some coordination by delineating a health care plan for foster parents and health care providers. Both programs use contracted health professionals to compile and document the medical and mental health conditions, prescriptions, equipment, and other medical needs of children in foster care but are not clinical care coordination programs. In addition, both programs are relatively high cost mechanisms for medical record review and are not necessarily the most cost-effective use of contracted professional resources.

One other area of ongoing difficulty is the identification and diagnosis of developmental disabilities for children in foster care. Physicians report that the tools used to diagnose developmental disabilities are time consuming and they are not reimbursed for the additional time spent administering the tools.

The Governor's Budget has requested funding for a pilot to establish one or more Centers of Foster Care Health (CFCH). The CFCH will be designed to improve primary care for foster children. Physicians who participate in the pilot will be required to meet certain criteria. One of those requirements will be to enhance developmental screening for foster children. Training opportunities for physicians will be offered through the "Centers for Foster Care Health".

Dental Care

Children in foster care have a difficult time accessing dental and orthodontic services. The biggest challenges for dental and orthodontia care are the limited services provided through Medicaid and the lack of incentive for dental providers to participate in the state's Medicaid program. Due to low reimbursement rates, there are few dentists and even fewer orthodontists willing to accept Medicaid clients.

Even if an orthodontist is willing to accept Medicaid reimbursement, the Medicaid rules prevent HRSA from approving orthodontic treatment for children who do not have severe malocclusions – such as a craniofacial defect. This creates a "parallel system" where state foster care dollars are used to pay for orthodontia for children who desperately need the treatment but who do not meet the strict Medicaid rules.

HRSA has a representative who participates on Access to Baby and Child Dentistry (ABCD) workgroups to ensure that the concerns for children in foster care are represented.

Mental Health

Foster children may receive mental health services through a variety of doors. The main door for Washington State children in foster care is through the Regional Support Network (RSN) system. Foster children are entitled to a mental health evaluation within the appropriate RSN service provider network. Ongoing care must be assessed in terms of the statewide access-to-care standards. The Access to Care Standards capture and identify the most severely disturbed children and youth for on-going mental health treatment.

A discrepancy occurs between the need for mental health services and the availability of services for children in foster care. This appears to be especially true for children in the mild to moderate range of mental health conditions. Many children are identified as having mental health concern but their needs are not severe enough to meet the Mental Health Division's Access to Care Standards. These children cannot receive mental health services through the RSN.

Foster children are eligible to receive 12 mental health visits per year through their fee-for-service medical. These visits occur outside of the RSN system. The visits must be with an “M.D.” – such as a psychiatrist and are most often used for monthly medication management.

Available information strongly suggests that although the RSN system provides quality care to many of these children, the system does not have sufficient resources to meet all of their mental health needs. Recent data analyzed by the Division of Research and Data Analysis (RDA) indicates that approximately 35% of 12,149 children in out-of-home placement during SFY 2004 received at least one Mental Health Division service at a total cost of \$18.8 million, or \$4,445 per capita expenditure. The cited average probably underestimates intensive services that were actually utilized in this high needs population, because of the capitated rate. The public mental health system does provide a significant amount of mental health care to children in foster care.

The persistence of unmet need for mental health care within the foster care population is supported by the presence of another “parallel system” of mental health services that are financed using regional Children’s Administration funds. CA spent approximately \$4.2 million in SFY 2005 for regionally contracted state-funded mental health services to children in foster care. These dollars are mostly spent for adults and children who are court ordered to have psychological evaluations as part of court proceedings. There is very limited, short-term counseling provided through these funds. In addition, when CA is not able to access Title XIX Medicaid dollars they must use state funded foster care dollars to pay for these services.

Preliminary information from RDA indicates that 24% of the approximately 19,000 children within a more inclusive definition of foster care during FY 2004 (a larger group than cited above) had some diagnostic or pharmacy claims-related indication of mental illness, of which 1/3 were classified as severe. Based on available information, 29% of these children with a severe mental illness that received DSHS medical services, and 52% of the children with a less severe mental illness, were not served by the RSN system (RDA/Mancuso 2006). These unserved children either received mental health services purchased by the Children's Administration, or received no mental health care.

Mental Health services contracted through Children’s Administration or fee-for-service address only some of the gap between anticipated need and the actual services available. Children’s Administration contracted mental health services are mostly for court-ordered psychological evaluations for adults and children. There is also very limited capacity for short-term on-going counseling services. The fee-for-service benefit is 12 sessions, one time a month primary with a psychiatrist for medication management. The benefit does not cover any on-going counseling services.

Child Health and Education Tracking (CHET)

CA redesigned the Kidscreen and Passport programs into one integrated program called Child Health and Education Tracking (CHET). In July 2006, the new CHET

program was implemented statewide in the CA field offices. The new program design allows for better coordination of services and improves the process of identifying and addressing the short and long-term needs of children in foster care.

CHET is designed to identify and organize essential information about the health, development, connections, education and mental health of all children in departmental care or custody and who are expected to remain in care 30 days or longer. CHET brings together efforts between the Children's Administration (CA), HRSA, the local Public Health Jurisdictions, Regional Service Networks, community providers, and local school districts to improve the overall health, mental health and educational well-being of children in out-of-home care. Well-being needs include health, mental health, education, developmental, substance abuse and connections of the child to people and organizations in their lives.

The health component of the CHET screening is the EPSDT examination. The initial EPSDT examination is to take place within 30 days of the child's placement into out-of-home care. The EPSDT examination covers the identification of any physical health, developmental, dental and mental health needs. In addition, CHET screeners perform mental health and developmental screenings using several evidence-based tools such as the Child Behavior Checklist, the Ages and Stages Questionnaire and the GAIN-SS.

CHET social workers only use the GAIN-SS for youth aged 12 and older to screen for substance abuse, mental health and co-occurring disorders. The results of the screening are incorporated into the child's case plan – which meets one of the Braam requirements for mental health. In addition, utilizing the GAIN-SS meets other Braam requirements around identifying and referring children to appropriate mental health and substance abuse services.

The new CHET model outlines specific criteria for children with complex or untreated health and mental health needs to be referred to the FCPHN (Foster Care Public Health Nurse, formerly Passport Nurse) during the CHET screening process. Under the previous design, children were not referred to the Passport program until they were in foster care for 90 days. The FCPHN evaluates medical records and information in order to write a Comprehensive Health Report (formerly a Passport). The Comprehensive Health Report is given to caregivers and medical professionals to provide them with necessary information in caring for the child.

Once the CHET screening is complete, the CHET social worker writes a report which includes the results of the child's EPSDT examination and the Comprehensive Health Report if one is written. The screening report is shared with caregivers, pre-adoptive parents and social workers at the Shared Planning Meeting. The CHET screening report is used in placement decisions, case planning and identification and connection to services that will help the child grow and thrive.

Infant Toddler Early Intervention Program (ITEIP)

In 2004, CAPTA legislation required that CA staff refer children with substantiated cases of child abuse and neglect to the DSHS Infant Toddler Early Intervention Program (ITEIP) system. ITEIP and CA met and agreed to refer children identified with possible developmental concerns through the CHET screening process to the ITEIP Family Resource Coordinator in their community. This requirement has increased the number of referrals to ITEIP for children in foster care. It also provides a mechanism for the early identification of possible developmental concerns as required by the Individuals with Disabilities Education Act, Part C and the Washington Infant Toddler Early Intervention Program.

For tracking purpose, a formal agreement has been documented as a memo of understanding between DSHS: ITEIP, CA, and Research and Data Analysis (RDA) to perform annual data matches for all ITEIP initial contacts, matched with CA children in foster care.

Region 6 Psychotropic Medication QA Review

In 2003, HRSA conducted a review of the management and coordination of health care provided to foster children prescribed psychotropic medications. A sampling of children in Region 6 who had been continuously enrolled in foster care for calendar year 2002 was selected for review. The Oregon Medical Professional Review Organization (OMPRO) performed the review as external quality review contractors for HRSA. A review of 136 client records indicated that a large majority of the records reviewed contained diagnoses for a mental health condition and the use of psychotropic medications, 94% and 83% respectively. While the class of medication used was also appropriate to the diagnosis for a majority, of cases (77%), less than half of the cases documented evidence of medication education to foster parents or coordination of mental health needs. A later sub-analysis of the data that Dr. Bergman initiated suggested that 22 children in the sample could benefit from more in-depth analysis to determine the appropriateness of their prescriptions.

Dr. Tim Truschel, child psychiatrist and Region 6 medical consultant for Children's Administration reviewed the 22 cases further and found that overall use of the medications was consistent with the needs of this high risk subgroup of children. The prescription of multiple psychotropic medications occurred nearly exclusively with children who had a prescriber working with a psychiatric consultant. Many of the children were no longer on medicines. Suggestions from Dr. Truschel included routine collection of current medical notes that would allow timely professional review.

HRSA Sponsored Psychotropic Medication Guidelines

In November 2005 Dr. Jeff Thompson, Chief Medical Officer at HRSA, began developing a pediatric psychotropic medication quality improvement project that is aimed at implementing a more evidence-based policy to govern the use of these medications among all HRSA clients. Dr. Thompson has developed evidence-based age and dosage guidelines for the use of ADHD and antipsychotic medications in children. These guidelines are based on medication reviews prepared by OHSU and

RAND, with collaboration from providers, advocates, industry stakeholders statewide as well as approval by the State Drug Utilization Review Board. Similar initiatives in Texas and Massachusetts have also provided some guidance.

The Washington state initiative requires providers who prescribe these medications outside of evidence-based guidelines, to obtain 2nd opinions from pediatric psychiatry experts. Although they are not currently being tracked, children in foster care are integral participants in this evidence-based review.

Recommendations

- HRSA to undertake a further review and analysis of options to improve quality of and access to mental and behavioral health care for children in foster care.
- CA will contract with qualified mental health professionals to act as mental health liaisons between the mental health system and social workers, clients and caregivers. The Mental Health Liaisons will connect children who do not meet the RSN access-to-care standards with other community mental health resources.
(Funding for this recommendation was included in the Governor's Budget.)
- DSHS to develop a way to assess quickly and reliably how many children in foster care are currently being served by the whole range of mental health providers.
- The OFCH will participate in departmental efforts that evaluate the processes and procedures for:
 - ✓ Recruitment of providers (physicians, dentists, orthodontists).
 - ✓ Reimbursement rates to providers.
 - ✓ Access-to-care standards for dental and orthodontic care.
 - ✓ Relaxation of access-to-care standards so that all children in foster care can access mental health care through the RSN.
 - ✓ Specific contracting with an administrative organization to guarantee a mental health provider network.
 - ✓ Enhancement of the Medicaid fee-for-service mental health benefit to allow a variety of licensed mental health providers to care for children in foster care for more than the currently allowed 12 visits.
 - ✓ Exemption of children in foster care from the Regional Support Network (RSN) delivery system.
- The OFCH will begin developing process and components of an initial 72 hour health screening for children entering foster care.
- CA and ITEIP staff to continue to maximize the number of foster children referred to ITEIP.
- CA, RDA and ITEIP to continue work on identifying the number of foster children referred to ITEIP.
- HRSA will emphasize the diagnosis of developmental disabilities in conjunction with developing criteria for physicians participating in the Centers for Foster Care Health.
- Continue to include foster children in DSHS evidence-based initiatives, with special attention to identifying treatments for children who have more intensive needs.

Note: See section G for additional recommendations pertaining to mental health issues.

D. Improving access to health information available to the Children's Administration for providers of health services for children in foster care, including the use of the CHILD Profile as a means to facilitate access to such information

Child health information that is vital to providing appropriate care for children in foster care is potentially accessible through internal DSHS resources. This includes the billing information from the MMIS claims system as well as Child Health and Education Track (CHET) screening information. However, the information is not always available in a timely and easily accessible fashion.

The survey results collected in preparation for this report indicated several ongoing issues with regard to access of health and mental health information. According to the respondents:

- Medical records of children in foster care are often not available, may be incomplete, or are not current.
- Community physicians are uncertain of whether they can release records to the department and when it is appropriate for foster parents to consent to treatment or the release of records.
- The department is commonly asked to pay for medical records, which arrive with delay and may be redacted to the point where they are not comprehensible.
- Despite statewide availability to physicians of the CHILD Profile web-based immunization registry, immunization information is incomplete, which results in both over- and under-immunization for children in foster care.

The need to access health information for staff, foster parents and health and mental health care providers has been identified for several years. In response to this need, CA and HRSA have implemented several strategies that make the information more available.

Sharing Medicaid Billing Information with Providers

CA and HRSA have made changes to their electronic systems which improve access to medical information for CA staff. Recommendations have been made to the ProviderOne development teams which include the ability for direct access by health care providers to the information as well as the capacity for data to be accessed, displayed and printed in a more user friendly manner. These improvements are anticipated to be included later in the development of the ProviderOne information system at HRSA. Until ProviderOne is able to address these issues, health and mental health care providers for children in foster care need an interim solution to the difficulty of acquiring medical information for children in foster care

As an interim solution, CA implemented pilots with several providers around the state. The pilots met with limited success. However, they afforded an opportunity for CA to discover what information providers find useful and to assess different mechanisms for the information to be made available. The pilots were set up so that the clinics could contact specified CA staff in order to have the information emailed to them through the DSHS secure email server.

The first pilot site was the Mary Bridge Children's Clinic in Tacoma which is considered a center of excellence for foster care health. However, a large portion of the foster children seen at the clinic were existing patients prior to entering foster care. Therefore, the information supplied by DSHS was already part of the patient's file and available to the clinic physicians. In light of this, the Mary Bridge Clinic no longer makes requests for information.

A second site was established with Dr. Roy Simms from Yakima Pediatrics. Yakima Pediatrics has found the information to be very useful and continues to request information on children seen in their clinic (about 4 - 5 children per month).

Two more pilot sites were established as of October 1, 2005 between the Children's Hospital Emergency Room and Central Intake and between the Odessa Brown Clinic and the Region 4 daytime intake office. Central Intake and Region 4 intake are trained and ready to receive requests but very few requests have been made since the start of these pilots.

Improved access to medical information for CA staff

Medical records of children in foster care are not always available, may be incomplete or are not received in a timely manner. It is not always clear for physicians when it is appropriate for them to release records to CPS/CWS. In addition, the department is frequently asked to pay for the requested medical records, which arrive with delay and may be redacted to the point where they are not comprehensible. Child immunization information is incomplete, and results in both over- and under-immunization, despite statewide availability of the CHILDP Profile web based immunization registry.

In 2002 the Children's Administration and HRSA collaborated to develop a link in CAMIS to the MMIS billing data maintained by HRSA. It is this link that was accessed in the pilots discussed above. A condensed and redacted sample of the information is attached to this report in Appendix F. CA workers are able to browse the available medical information for children on their caseload through a simple hyperlink mechanism built into each electronic case record.

The MMIS billing data contains vital information which can be used to manage the health care of children in foster care. While not a complete medical history, information regarding diagnosis, treatment, medications, and provider names and addresses is available. This is a resource with great potential and it is available to CHET screeners, SSI Facilitators, FCPHNs, and social workers. However, use of the interface has been

limited by difficulty with printing the information in a readable form. As of August 4, 2006, the Children's Administration initiated an enhancement to CAMIS that will enable social workers to display, sort, and print summary medical information from the MMIS link for children in foster care. This enhancement should be available to CA staff by December 2006.

Child Information Form

The Children's Administration designed the Child Information Form (DSHS 15-300) in order to collect the important need-to-know information at the time of a child's placement into out-of-home care. The form was implemented and made available to the field in July 2006. The Child Information Form provides foster parents with information that will ease the child's transition into their home as well as provide important health and mental health information. The form is completed by the assigned social worker either by hand or on the computer and is given to the caregiver within 72 hours of the child's placement. A sample of this form and the instructions for its use are attached to this report in Appendix C.

Clarification of Consent to Health Care Information

Research done for this report indicated that there is general confusion related to consent to treatment and release of information for children in foster care. To address this issue, the program attorney for the Children's Administration wrote a legal memo which clarifies the department's authority and responsibility to consent to medical treatment and to delegate certain types of authority to foster parents. It also clarifies issues related to the release of medical information by providers to the department or foster parents and payment to providers for requested records.

The memo was made available to CA staff and foster parents in June 2006. HRSA is in the process of sending the memo out to their providers in a mailing. The memo is attached to this report in Appendix E.

Exploration of CHILD Profile as a resource for storing and improving provider access to medical information for children in foster care

The initial purpose of CHILD Profile was to provide a central registry for immunization information. Medical providers may subscribe to the registry at no cost. However, there are still many providers who do not subscribe to this service. Children in foster care would benefit from providers who accessed CHILD Profile in order to avoid under- or over- immunization.

CHILD Profile immunization data is accessible to some staff in the CA field offices. There is a potential benefit in allowing access by additional social work and CHET staff to CHILD Profile. The information could be used in registering children for school as well as a tool in the gathering of baseline information about children when they are initially placed into foster care.

The Department of Health was funded to contract for a report to be written regarding broadening the use of CHILD Profile to include direct access by physicians to the Medicaid Billing data housed at HRSA. Staff from CA and HRSA met with the DOH CHILD Profile contractor to discuss the various needs of our administrations in accessing medical information and what information should be shared with providers and caregivers. These discussions included the feasibility of using the CHILD Profile web based system. The DOH report is separate from this report.

Recommendations:

- HRSA to continue to pursue direct access for physicians to the Medicaid Billing Data.
- Future enhancements to the CA SACWIS system should include the ability for the Child Information Form and other forms to be automatically generated based on the information entered into the system.
- CA should work with DOH to provide access to CHILD Profile to CHET social workers and case carrying social workers.
- HRSA and DOH should work together to develop incentives for providers to subscribe to CHILD Profile.

E. Establishing a medical home for each child placed in foster care to ensure that appropriate, timely, and necessary quality care is available through a coordinated system of care and analyzing how a medical home might be utilized to meet the unique needs of children in foster care.

The American Academy of Pediatrics (AAP) recommends that all children would benefit having a medical home. Children in foster care can especially benefit from the type of comprehensive care available through a medical home. Medical homes provide a central conduit for referrals and repository for records, thus allowing for consistent, coordinated and comprehensive health and mental health care.

Medical homes are new to Washington and therefore the concept is still being defined for our state. Providers have expressed concern regarding the fiscal impact to their clinics if they are to provide the kind of comprehensive care that is outlined by the AAP in their definition of a “medical home”. There are several initiatives and workgroups that are trying to promote and establish the medical home concept in our state. CA and HRSA are active participants with the workgroups affiliated with these initiatives. Children with Special Health Care Needs (CSHCN) through DOH are sponsoring one initiative and they have included children in foster care in the definition of CSHCN.

The state of Illinois has successfully implemented the medical home and a “center of care” model through a contractual arrangement with an administrative service organization in the city of Chicago. The contractor, HealthWorks, is responsible for provider recruiting, training, retention, and quality assessment. HealthWorks also

recruits foster parents for voluntary participation as participants in the preferred provider organization.

Medical homes are an excellent mechanism for all children to receive comprehensive health care. However, medical homes are not necessarily familiar with the special needs of children in foster care. To address this gap, HRSA has begun preliminary discussions to establish "Centers of Foster Care Health" (CFCH). If the fiscal and logistical concerns can be addressed adequately, initial pilot sites may be established in 2007.

The premise of CFCH is to provide initial screening and evaluation as well as medical/technical assistance to medical home providers in managing the complex needs of children in foster care and to provide specialty care when needed. While some children would obtain primary care services in CFCH, limitations of distance and geography dictate that many children would receive primary care at individual providers' offices, with periodic re-evaluation at the CFCH.

Centers of Foster Care Health would be financed through special contracts with certain hospitals and local specialty groups. Another option to fund the CFCH concept is for HRSA to establish a primary care case management (PCCM) model which could offer financial incentives for primary care providers to provide the comprehensive care that children in foster care need. Both of these types of funding would have associated expectations that would guarantee children in foster care access to specialty care as needed, and guarantee primary care providers' access to technical expertise and education about health risks for children in foster care.

Recommendations:

- HRSA consider allowing flexibility from the usual fee-for-service health care reimbursement for children in foster care to allow for financial incentives to providers and clinics who become Centers of Foster Care Health.
- The DSHS Office of Foster Care Health should work to establish at least one "Center of Foster Care Health" as a pilot for a statewide program. The pilot program would initially serve up to 2000 children in one or more sites. Possible pilot sites include Sacred Heart in Spokane, the Children's Village in Yakima, MaryBridge in Tacoma and the Children's/Odessa Brown Clinic in Seattle. (*Funding for this approach was included in the Governor's Budget.*)
- The department should support the development of comprehensive medical homes for children in foster care.
- HRSA and CA to continue to participate on statewide medical home initiatives.

F. Examining how existing resources are being utilized to provide health care for foster children and options for improving how the resources are utilized. Particular emphasis shall be placed on the following:

- (i) Whether the health care services provided to foster children are evidence-based;

- (ii) Whether resources are duplicative or redundant between agencies or departments in the provision of medical, dental, or mental health services for children; and
- (iii) Identification of where resources are inadequate to meet the routine and necessary medical, dental, and mental health needs of children in foster care;

The Children's Administration has recently completed a comprehensive review of their contracts. One major criterion of the review was to determine whether the treatment or service was evidence-based. CA has hired a program manager to support the migration to Evidence-Based Practice where appropriate.

In addition, HRSA is working towards ensuring that programs and services paid for with Medicaid dollars are evidence-based. Most recently, psychotropic medication guidelines established by HRSA are supported by evidence-based research. To date, the HRSA psychotropic drug initiative has been able to identify children in foster care who require more intensive monitoring because of an unorthodox use of psychotropic medications, outside of national guidelines. When such use is identified, HRSA has established protocols for contacting the prescribing physician to determine the continued appropriateness of the medication.

As stated previously in this report, there are inadequate resources to address the mental health and dental needs of children in foster care. When any service (medical, dental, mental health) cannot be covered by Medicaid through HRSA, the Children's Administration will pay for the service with their state-funded foster care dollars. Use of these funds reduces the amount of state dollars available to fund other non-medical services that children in foster care need.

Recommendations:

- Continue to include children in foster care in evidence-based HRSA initiatives, with special attention to identification of children whose care is outside of established norms.
- RDA, CA, HRSA to determine the feasibility of being able to track services for children in foster care separately from the general population receiving services from DSHS.
- Continue to work on resolving authorization and payment issues related to services that should be covered by Medicaid but are sometimes paid for by CA i.e. mental health services.

G. Any other issues related to medical, dental, or mental health care for children in foster care

Cross-education of HRSA and CA staff

CA social workers frequently face difficulties when navigating the HRSA and Medicaid systems. In addition, HRSA staff are not familiar with how foster care cases differ from the usual DSHS medical cases. Dr. Anderson did a presentation/training for HRSA staff. The presentation included case scenarios where children faced various difficulties in accessing needed health or mental health services. This presentation received a positive response from the staff who attended. The presentation was done again at an EPSDT meeting which included attendees from other departments as well as some community partners. Again, the presentation was met with a lot of positive feedback. The Office of Foster Care Health plans to make this presentation available to other groups as the opportunity arises.

The creation of the DSHS Office of Foster Care Health will go a long way toward educating CA and HRSA staff about the special health and mental health issues faced by children in foster care. On-going training opportunities need to be made available to the staff of both administrations.

Mental Health Transformation Grant

CA has been integrally involved in the Mental Health Transformation Grant (MHTG) process, as the co-chair for the Children's Subcommittee and in the Transformation Workgroup. The Transformation Workgroup has just prioritized 3 outcomes out of 27 that the Grant will focus on in the next 4 years. The Transformation Grant is only for building infrastructure, it cannot be used for services.

The top priorities identified by the Transformation Workgroup may benefit CA clients by:

- Serving the whole family and exploring how parents can stay on Medicaid for services when their child goes into foster care thus providing support to the family toward reunification.
- Increasing community based mental health services for children including Evidenced Based Programs.
- Revisiting the Access to Care Standards in an effort to allow families services sooner rather than waiting until they are in severe crisis.
- Decreasing the number of families that seek Voluntary Placement Agreements for services in Children's Administration due to parental mental illness.

All of these, if possible and implemented would help children in foster care and their families by creating a more responsive, more effective and more supportive mental health system.

In addition, MHD and CA will work to augment mental health services and treatment for foster children with mild to moderate mental health needs. Funding for this approach was included in the Governor's budget and if the legislature appropriates this funding, mental health liaisons will be contracted for in the CA regional offices to connect children with the RSNs and other community mental health resources. The liaisons will

be of particular assistance for the children who do not meet the current “Access to Care Standards” of the mental health system and often “fall through the cracks”.

Braam Settlement Agreement

Mental health outcomes are a key goal in the Braam Settlement Implementation Plan. Some of the outcomes are related to Child Health and Education Tracking and involve the screening of health and mental health needs as well as timely Early Periodic Screening Diagnosis and Treatment (Well-Child) examinations. Other outcomes are related to having a responsive DSHS mental health system through the Regional Support Networks system including:

- Timeliness of services
- Access to care
- Notice of action when services are denied
- Crisis service availability
- Co-mingling of children in adult acute hospital settings
- Continuity of care providers
- Efforts to discourage the use of student interns as therapists for foster children in community mental health settings

In January 2007, CA will implement the Global Assessment of Individual Needs – Short Screener (GAIN-SS). The GAIN-SS is part of the effort to implement Senator Hargrove’s Omnibus (5763) bill concerning co-occurring disorders. It is anticipated that more foster children who have mental health needs will be identified through this additional screening mechanism. Because of this, there will be an on-going need for coordination between the Mental Health Division and the Children’s Administration.

Recommendations:

- Continue to provide training regarding the special health and mental health needs of children in foster care to internal and external partners.
- CA to continue to participate in efforts with the Mental Health Transformation Grant as well as other efforts that address the gaps in mental health services available to children in foster care.
- Encourage cross-administration education of HRSA and CA staff to change the culture and knowledge about foster care health.

III. Medical Consultants

- (a) The foster care health unit, in collaboration with regional medical consultants, shall develop a statewide, uniform role for the regional medical consultants with emphasis placed on the mental health needs of the children in foster care.

- (b) By September 1, 2006, the department shall implement the utilization of the statewide, uniform role for the regional medical consultants.

In June 2002, CA began recruiting physicians to be medical consultants in the regions. The purpose of the medical consultants is to assist field staff in understanding the health and mental health needs of children in foster care. With the assistance of Dr. Bergman, a focus was placed on recruiting pediatricians. Currently CA has at least one part-time consultant in each region. The medical consultants report to the Regional Administrators and are key members of the regional management team. The regions have developed protocols for staff to access the medical consultants in order to maximize the resource. The medical consultants are available to consult with staff to assure that foster children are receiving appropriate specialized assessment and services. They are also responsible for working with local medical communities to improve access to health services.

A uniform statewide position description for medical consultants has been approved by the regional medical consultants and the CA Management Team. The revised definition has been distributed to CA staff.

Recommendation:

- CA to continue to recruit and hire CA medical consultants and explore options to provide mental health consultation to health and mental health care providers and social work staff.

Appendix A: Glossary

CAMIS - Children's Administration Case and Management Information System – The Children's Administration electronic system that stores all case management information regarding children involved with Children's Administration.

Children's Administration (CA) – The administration within the department of social and health services responsible for the provision of child welfare, child protective, child care licensing, and other services to children and their families.

Child Health and Education Tracking (CHET) – The integration of Kidscreen and Passport into a single program to address the long-term well-being needs of children in foster care. CHET screens children who are expected to be in out-of-home care 30 days or longer. Children are assessed in physical health, development, connections, education and mental health.

Client – An applicant for, or recipient, of DSHS programs.

Department – The state Department of Social and Health Services (DSHS). (WAC 388-500-0005)

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – A program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. (WAC 388-500-0005)

Fee-for-Service – A payment method HRSA uses to reimburse providers for covered medical services provided to medical assistance clients, except those services provided under HRSA's prepaid managed care programs. (WAC 388-500-0005)

Foster Care – Program administered by the Children's Administration to provide out-of-home care to children who are unable to live in their own homes.

Foster Care Assessment Program (FCAP):- FCAP is a statewide contracted program available to children in foster care. The program provides a comprehensive assessment of a child's level of functioning in the home, school and community, and is used for children with complex medical and/or behavioral needs to create a plan for overall service needs and permanency. For additional information, go to <http://depts.washington.edu/hcsats/FCAP/>.

Foster Care Meds Team (FCMT) – The FCMT is the eligibility team at HRSA responsible for issuing medical identification cards for all children placed by the department into foster and relative care. This unit also issues medical identification cards for children in the Adoption Support Program. FCMT is considered part of the HRSA Foster Care Health Unit.

Appendix A: Glossary continued

Foster Care Public Health Nurse (FCPHN) –

The CA contracted Public Health Nurse who develops recommendations based on compiled health information, in order to advise the department and caregivers on the health and mental health needs of children in foster care who have complex or unaddressed health and mental health needs.

Health and Recovery Services Administration (HRSA) – An administration within DSHS responsible for disability determinations, medical care, mental health services, and alcohol/substance abuse prevention and treatment for low-income residents of Washington State.

Healthy Options (HO) - HRSA's prepaid managed care health program for Medicaid-eligible clients and CHOP clients. (WAC 388-500-0005)

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider. (WAC 388-500-0005)

Medicaid – The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Identification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical program. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medical consultant – Physicians employed by the department and available to CA staff for consultation regarding health and mental health issues for children in out-of-home placement.

Medically Necessary – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, “course of treatment” may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Appendix A: Glossary continued

Primary Care Provider (PCP) – a person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referral for specialist and ancillary care, and maintains the client's or enrollee's continuity of care. (WAC 388-538-050)

ProviderOne: new Medicaid Management Information System (MMIS) under development that will process claims to pay doctors and other health care and social service providers around the state for the services and treatment DSHS clients receive.

Provider or Provider of Service – An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department. (WAC 388-500-0005)

Appendix B: Resources/References

Almgren, G. & Marcenko, M., University of Washington prepared for DSHS, Medical Assistance Administration, First placement in foster care and the timing of the first episode of medical care: Analysis of a sample of children first placed in foster care in fiscal year 1999; University of Washington, Seattle Campus: Center for Research in Prevention.

Almgren, G. & Marcenko, M., University of Washington-School of Social Work. (2001). Emergency Room Use Among a Foster Care Sample: The Influence of Placement History, Chronic Illness, Psychiatric Diagnosis, and Care Factors; Oxford University Press, Seattle Campus: Center for Research in Prevention

American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care, Health care of foster children. Pediatrics (1987). 79, 644-646

American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care, Health Care of Young Children in Foster Care. Pediatrics. (2002 March). 109 No. 3, 536-541.

American Academy of Pediatrics, District II New York State, Task Force on Health Care for Children in Foster Care, (2001). Fostering Health: health Care for Children in Foster Care, 52 pp

Bergman, A: The Shame of Foster Care Health Services. Archives of Pediatrics and Adolescent Medicine (2002 November) 154 No 11, 1114-17.

Casey Family Programs Research Services: Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study. Casey Family Programs, Revised 2005, Retrieved 7/24/06 from www.casey.org

Chestnut Health Systems, Global Appraisal of Individual Needs - Short Screener (GAIN-SS). Services: Research & Training, Lighthouse Institute, (2005). Retrieved 03/09/2006, from http://www.chestnut.org/LI/gain/GAIN_SS/

Child Welfare League of America. Standards for Health Care Services for Children in Out-of-Home Care. Washington DC: Child Welfare League of America; 1988

Division of Research and Data Analysis, DSHS /Mancuso, D: Preliminary Mental Illness Severity and Cost Calculations; Unpublished Data (2006)

Halfon, N, Flint, R, Inkelas, M: Health Agency Roles in Health Services for Children in Foster Care. Health Services for Children in Foster Care (2002, September) No 3, 11 pp

Halfon, N, Flint, R, Inkelas, M: Child Welfare Agency Use of Standards for Health Care to Children in Foster Care: Health Services for Children in Foster Care (2002, September) No 2 13 pp.

Appendix B: Resources/References, continued

Halfon, N, Inkelas, M, Flint, R, Shoaf, K, Zepeda, A, Franke, T: Assessment of Factors Influencing the Adequacy of Health Care Services to Children in Foster Care Executive Summary. (2002 December) UCLA Center for Healthier Children, Families, and Communities pp i-xxxiv

Massachusetts Department of Mental Health, Children and Adolescents' Psychoactive Medication Workgroup: Psychoactive Medication for Children and Adolescents: Orientation of Parents, Guardians, and Others. Revised January 2005

McCue Horwitz, S., Owens, P., & Simms, M. D. Specialized Assessments for Children in Foster Care. *Pediatrics* (2000.July) 106 No1, 59-66. Retrieved February 6, 2006 from <http://www.pediatrics.org/cgi/content/full/106/1/59>

Medicaid Eligibility Quality Control Unit/Shineman J and Simmons R: Final Report Medicaid Eligibility Quality Control Project #26: Foster Kids—Access. (2002 January) Medical Assistance Administration Department of Social and Health Services, Olympia Washington

Oregon Medical Professional Review Organization (OMPRO): Foster Care Mental Health Review. Prepared for Medical Assistance Administration (2003); 5 pp.

Oregon Medical Professional Review Organization (OMPRO): Foster Care Project: 2nd Remeasurement Dec 2002 –January 2003. Prepared for Medical Assistance Administration (2003); 3 pp.

Oregon Medical Professional Review Organization (OMPRO)/Carol Foley, Ph.D: Well Child Focus Groups: Report of Findings: Prepared for Medical Assistance Administration (2003); 59 pp.

Rosenbach, M., Lewis, K., & Quinn, B. (2000, September 19). Health Conditions, Utilization, and Expenditures of Children in Foster Care. Chapter IV: Discussion; Cambridge, MA: Mathematica Policy Research, Inc. Retrieved on March 7, 2006 at <http://aspe.hhs.gov/hsp/fostercare-health00/index.htm>

Rubin, D, Alessandrini, E, Feudtner, C, Localio A, & Hadley T: Placement Changes and Emergency Department Visits in the First Year of Foster Care. *Pediatrics* 2004. 114 No 3; e1-e7 reprint

Simms, M. D., Dubowitz, H., & Szilagyi, M. A. Health Care Needs of Children in the Foster Care System. *Pediatrics*, (2000 October) 106 No. 4 Supplement pp. 909-918), Retrieved 02/06/2006, from <http://pediatrics.aappublications.org/cgi/content/full/106/4/S1/909>.

Takayama, J, Bergman, A, Connell, F: Children in Foster Care in the State of Washington: Health Care Utilization and Expenditures. *Journal of the American Medical Association* (1994 June 15) 271 No 23 pp 1850-1855.

Appendix B: Resources/References, continued

Task Force on Health care for Children in Foster Care: Fostering Health: Health Care for Children in Foster Care. (2001). District II, New York State: American Academy of Pediatrics.

Texas Department of State Health Services: Psychotropic Medication Utilization Parameters for Foster Children (2005) retrieved 8/3/06 from <http://www.dshs.state.tx.us/mhprograms/psychotropicMedicationFosterChildren.shtm>

SECTION I			
CHILD'S NAME		CHILD'S DATE OF BIRTH	CAMIS PERSON ID
CHILD'S RACE/ETHNICITY	PRIMARY LANGUAGE		NATIVE AMERICAN TRIBAL AFFILIATION
CHILD'S SCHOOL/CITY		GRADE	TEACHER(S)
Individual Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No		DATE OF LAST IEP	
For children 0-3, is child involved in Early Intervention Services? <input type="checkbox"/> Yes <input type="checkbox"/> No		DATE OF INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)	
CHILD CARE PROVIDER NAME			TELEPHONE NUMBER
NAMES OF SIBLINGS (under 18)	SEX (M/F)	AGE	LOCATION (HOME, FOSTER CARE, ETC.)
CONTACT PERSON FOR CAREGIVER (SOCIAL WORKER, PRIVATE AGENCY WORKER)			E-MAIL ADDRESS
AGENCY		TELEPHONE NUMBER	FAX NUMBER
ADDRESS		CITY	STATE ZIP CODE
SECTION II			
1. REASON FOR INITIAL PLACEMENT INTO FOSTER CARE: <input type="checkbox"/> Suspected physical abuse <input type="checkbox"/> Suspected sexual abuse <input type="checkbox"/> Suspected neglect <input type="checkbox"/> Mother incarcerated <input type="checkbox"/> Father incarcerated <input type="checkbox"/> Other:			
Does the child have health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		NAME OF PLAN	
Health insurance care given to caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Health Care Provider Name:	A.	B.	
3. Provider Type:			
4. Telephone Number:			
5. Does the child have any Medical appointments scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE	PROVIDER NAME	
6. Has the child received any immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	WHERE WERE IMMUNIZATIONS RECEIVED?		
IF YES, DESCRIBE:			
7. Does the child have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
IF YES, DESCRIBE:			

8. Has parental consent been obtained for medications? (Per CA Practices and Procedures Manual, Chapter 4000, Section 4541). <input type="checkbox"/> Yes <input type="checkbox"/> No						
MEDICATIONS	REASON FOR TAKING MEDICATION	WHO PRESCRIBED	DOSAGE	LENGTH OF TIME ON MEDS	GIVEN TO CAREGIVER	
					YES	NO
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any health concerns or limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
IF YES, DESCRIBE:						
10. Does the child have any emotional or behavioral concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No						
IF YES, DESCRIBE:						
Given the nature of out-of-home placement, there may be physical, emotional, medical, sexual, or other behavioral issues this social worker is unaware of at this time. It is difficult to predict the behavior and/or emotional issues of abused and/or neglected children, therefore close supervision of the child is expected and required. If you have any questions about the care or supervision of this child, contact the social worker. If an urgent mental health need is identified, the child should be referred immediately for Regional Support Network (RSN) services.						
11. Is there anything that the caregiver should know to make the transition to foster care or to a new foster home easier?						
This information is confidential under state and federal law. It is shared with the child's caregiver for the benefit of the child and the caregiver's family. The caregiver is prohibited by law from sharing this information with others unless the information is provided to a person who is responsible for the treatment or care of the child.						
SECTION III						
NAME OF CAREGIVER FAMILY						
CAREGIVER FAMILY SIGNATURE						DATE
A copy of this Child Information form was given to the resource family via:						
<input type="checkbox"/> Personally delivering a copy to the caregiver, (date)						
<input type="checkbox"/> E-mailing a copy to the caregiver at the following e-mail address:						
<input type="checkbox"/> Other (specify):						
SIGNATURE OF SOCIAL WORKER						DATE

Instructions to Complete Child Information Form

This form is to be given to the child's out-of-home caregiver within 72 hours of placement or placement change. The information contained on this form is meant to provide out-of-home caregivers with specific need-to-know information that can assist in providing a safe environment for the child, the caregiver and their family. The form may be completed either by hand or on the computer. If more space is needed when completing the form by hand, additional pages may be added and stapled to the form. If completing the form on the computer, the form fields are designed to expand with the amount of information being typed into them.

SECTION I

Each child being placed needs to have their own form. Complete all information known about the child as the boxes indicate. For school information, be sure to include the city that the school is located in as there are many schools in Washington that have the same name – i.e. Pioneer Elementary or Washington High School is not sufficient to determine where the child is enrolled.

SECTION II

1. Mark the appropriate box or indicate "other" with an explanation of why the child was placed in out-of-home care.
2. If the child has more than two health care providers, they can be listed in Section II, #10 with an explanation of why the child sees them.
3. List any licensed or certified professional who has seen the child: MD, Therapist, ENT, Psychologist, Psychiatrist, Dentist, etc.
4. If the provider's telephone number is unknown, gather as much information about the provider (physical location) so that the telephone number can be determined at a later time.
5. Describe special dietary needs such as feeding tube, special formula, extra time needed for feeding, if food needs to be locked up, anorexia, bulimia, and food allergies such as peanuts – anything that interferes with normal eating for a child at any age.
6. Be sure to get immunization information if possible to avoid over immunizing children coming into out-of-home care.
7. List any allergies the child has: bees, food, latex, mold, etc. Describe effects that the allergy has upon the child: stuffy nose, asthma attack, hives, unconsciousness, etc. Include information regarding any medications prescribed for treating the allergy; epi-pen, prescription allergy medication (Allegra, Nasonex, etc.), inhaler, etc.
8. Be sure to check with parents regarding all medications. If child is prescribed psychotropic medications, make sure to obtain parental consent per CA Practice and Procedures Manual, Chapter 4000, Section 4541. If more room is needed to list medications, attach an additional sheet to the Child Information form.
9. "Does the child have any health concerns/limitations?"
 - List and describe any health concerns or conditions of the child such as: lack of dental care, developmental concerns, asthma, diabetes, vision and/or hearing issues, prone to ear infections, renal failure, etc.
 - List and describe any equipment that should accompany or be obtained for the child such as: eye glasses, hearing aids, nebulizer, etc.

- List and describe the special needs of the child such as: special equipment, colostomy, feeding tube, lack of dental care, renal failure, etc.

Be sure to indicate to a physician seeing the child for the first time if the child was removed from a substance abusing environment – especially meth amphetamine laboratories.

- Upon any placement, DSHS shall inform each out-of-home care provider if the child to be placed in that provider's care is infected with a blood-borne pathogen (HIV/AIDS, Hepatitis, Etc.), if known by the department. (See Children's Administration Case Services Policy Manual, Chapter 4000, Section 4120, Paragraph A).

10. **Emotional and/or behavioral concerns should be described as completely as possible.** Remember to include triggers for behaviors, description of issues, information regarding assaultive or SAY concerns, skipping school, hoarding food – anything that will assist the caregiver in protecting their home and others in it as well as the child being placed in their care.

11. List items that will bring comfort to the child such as: blankets, pacifiers, pictures, music, routines, etc.

SECTION III

Be sure to keep proof that a copy of the completed form was given to the caregiver. If the form is provided to the caregiver in person, an additional signed copy should be obtained to keep in the child's care record – Well-being Binder.



Rob McKenna

ATTORNEY GENERAL OF WASHINGTON

670 Woodland Square Loop SE • PO Box 40124 • Olympia WA 98504-0124

MEMORANDUM

DATE: June 20, 2006

TO: Cheryl Stephani, Assistant Secretary
Children's Administration

FROM: Steve Hassett, Senior Counsel 
Office of Attorney General

SUBJECT: **CONSENT AND RELEASE OF INFORMATION FOR CHILDREN IN FOSTER CARE**

This memo is intended to clarify who may consent to medical treatment and to obtain medical history information for children in foster care. It may be shared with physicians and other medical practitioners to provide assistance for them in working with foster parents and Children's Administration social workers.

Unlike a child's biological parents, foster parents may not always have detailed knowledge of a child's medical history when they present a foster child for medical treatment or care. This may be especially so when foster parents need to obtain emergency medical treatment for a child shortly after the child has been placed with them. Valuable information regarding the child's past medical treatment may be contained in the State's Medicaid Management Information Systems databank which may be made available to physicians on an as needed basis.

1. **What Authority Does DSHS Have to Consent to Medical Treatment for Children in Foster Care?**

DSHS has the legal authority to provide the necessary informed consent for children in foster care for both routine and emergency medical care. DSHS has long had authority to "authorize evaluations of the child's physical or emotional condition, routine medical and dental examination and care, and all necessary emergency care" whenever a child is placed in its custody because of allegations of abuse or neglect. RCW 13.34.060(1)(b). In 2006, the State Legislature further clarified this to cover all children placed in ongoing relative or foster care as a result of a dependency proceeding: "Whenever a child is ordered removed from his or her home pursuant to this chapter, the agency charged with his or her care may authorize an evaluation and treatment for the child's routine and necessary medical, dental, or mental health care, and all necessary emergency care." Chapter 221 §2, Laws of 2006.



2. Can DSHS Delegate This Authority to Foster Parents?

For children in the legal custody of the Department, foster parents are delegated the authority held by DSHS to provide for and give informed consent to the routine and emergency medical needs of the children in their care. Pursuant to RCW 74.13.330, foster parents are responsible for “the protection, care, supervision, and nurturing of the child in placement.” In addition, DSHS has developed regulations and policies on the responsibilities of foster parents to act on behalf of the Department in providing medical treatment to children placed in their care. Washington Administrative Code (WAC) 388-148-0350 specifically states that DSHS may delegate its authority to consent to emergency and routine medical services on behalf of a child to both foster parents and facility-based care providers. Medical practitioners, providing medically necessary treatment and care to a foster child in an emergency room or similar setting, can assume that the foster parents of a child have sufficient legal authority to consent to the treatment and care of the child.

If a child has been placed with relatives by DSHS or the court, the relatives may have a court order specifying what authority they have to provide informed consent. In some circumstances, relative caregivers may also sign declarations pursuant to RCW 7.70.065(2)(a)(v) stating that they are responsible for the health care of the minor patient.

3. Does State Law or HIPAA Limit the Ability of Physicians to Access, Disclose and Use Information Regarding a Child’s Past Medical Care?

Valuable information regarding the child’s past treatment may be contained in the child’s existing case record as well as the State’s Medicaid Management Information Systems databank. The information contained in these two sources can be made available to physicians on an as needed basis. If the attending physician feels that he or she has a legitimate medical need for information regarding past medical care of a child in foster care, a request can be made for DSHS to supply any medical history information known to the department.

As long as DSHS is responsible for the physical placement of or has legal custody of a child brought in for medical treatment or care by the child’s foster parents, the Department can consent to the release of information in its case records as well as information contained in the MMIS databank as may be necessary for the treatment or health care of the foster child.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not bar DSHS from disclosing information to physicians providing treatment to foster children. Under the federal Department of Health and Human Services Privacy rules, DSHS can use and disclose protected health care information to another covered entity if the Department and the other covered entity both have a relationship with the foster child who is the subject of the protected

ATTORNEY GENERAL OF WASHINGTON

Cheryl Stephani
June 20, 2006
Page 4

or

Michelle Bogart, Foster Care Health Program Manager
Children's Administration
Bogm300@dshs.wa.gov

cc: Doug Porter, Assistant Secretary, Health and Recovery Services Administration
Kathy Leitch, Assistant Secretary, Aging and Disability Services Administration
Deb Marley, Assistant Secretary, Economic Services Administration
Sekou Shabaka, Assistant Secretary, Juvenile Rehabilitation Administration

Appendix E: Sample MMIS Billing Data

First	Last	Provider Name	Provider Address	Provider City	Provider State	Provider Zip	Provider Type	1 st Date of Service	Procedure	Diagnosis	NDC
		Auburn Regional Medical Ctr, Inc	Plaza #1 202 N. Division Street	Auburn	WA	98001-4908	Hosp Type III In State	19981014		FX DISTAL READIUS NEC-CL	
		Molina Health Care of WA, Inc.	21540	Bothell	WA	98021-0000	Health Maintenance Org	19990301	CAPITATION /SUPPLEMENTAL PREMIUM PAY		
		Woodinville Medical Center	17000 140 th Avenue NE # E101	Woodinville	WA	98072-6928	Pharmacist	199990304			CHILDRENS CHEWABLE WITH IRON