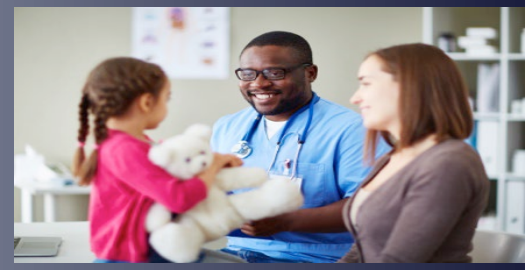






AHEC Pediatric Provider Webinar

Providing Care Access for Children/Youth in Foster Care

NC DHHS
Fostering Health North Carolina
Community Care of North Carolina

June 9th, 2022

Agenda

I. Child Welfare's Role in Supporting the Health of Foster Care Youth

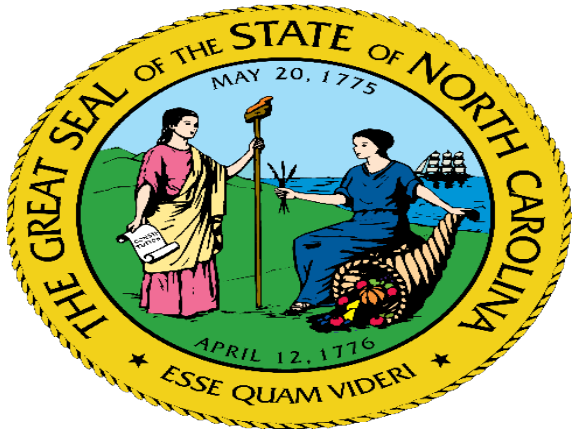
II. Medicaid Coverage & Supports for the FC Population

III. Best Practices for Treating Children/Youth in Foster Care

IV. CCNC Care Management Services for Children in Foster Care

V. CMARC Care Management Services for Children in Foster Care

Poll Question



Child Welfare's Role in Supporting the Health of Foster Care Youth

Jessica Frisina, MSW
Foster Care Coordinator
NC DHHS, Division of Social Services

Key Foster Care Health Stats and Findings

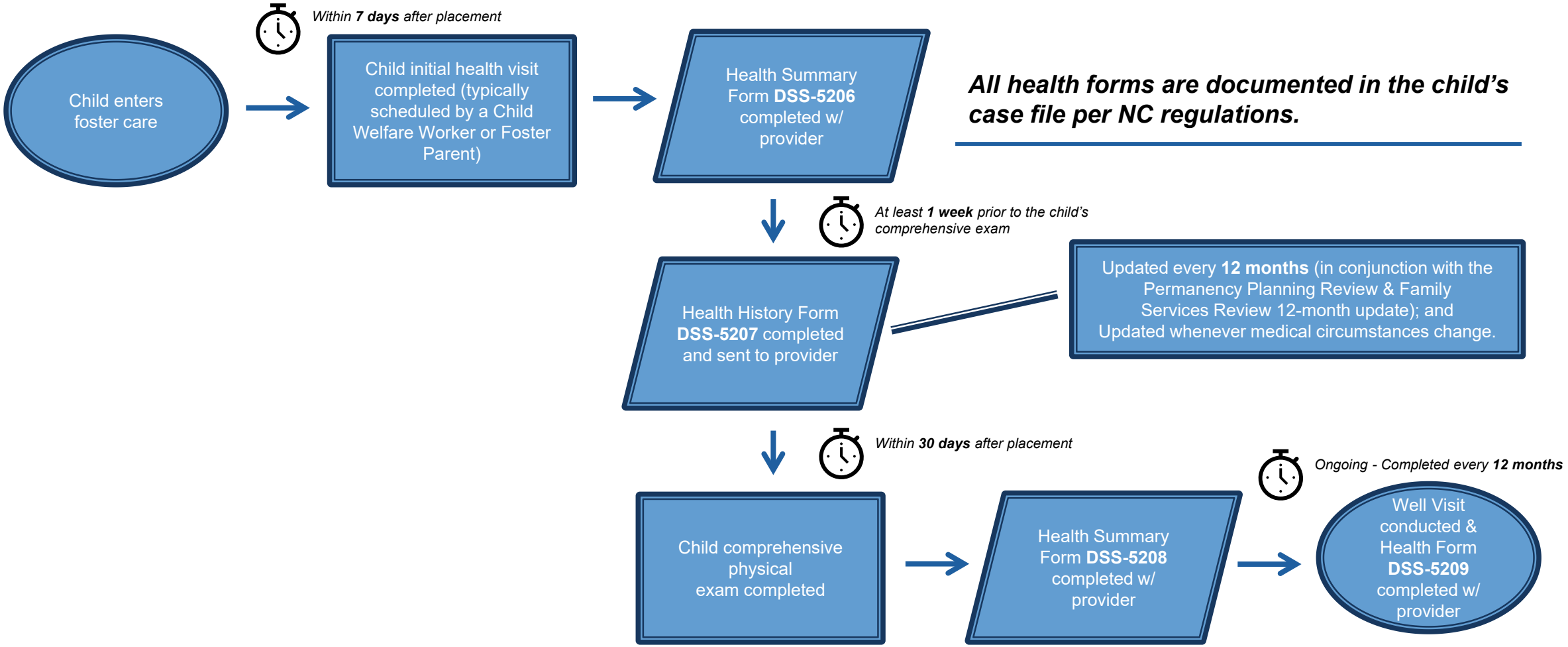
Children and youth in foster care face disproportional health risks compared to other children at their age

Foster Care Youth Face A….

- **Higher likelihood** of developmental delays; asthma; obesity; speech, hearing and vision problems; ADHD; anxiety; behavioral problems; depression; and other health and mental health issues
- **Significantly more** hospitalizations and subspecialty office visits than children not in foster care
- **Longer** average length of inpatient stays
- **Higher rates** of dental problems [one-third of children in care have not had a dental visit in the past year]
- **Higher likelihood** of substance abuse disorders and initiating use of substances at an earlier age

The Child Welfare Health Care Oversight Process

Child Welfare Workers use the following process to help connect foster youth to care upon entry into DSS Custody



Health Care Consent for Foster Care Youth

When children enter DSS custody, health care consent rules change to suit the evolved family dynamic

- **Placement Letter** – provided to medical provider by resource placement, placement agency, or custodial county
- Court orders *cannot be shared* unless otherwise specified in § 7B-2901
- **§ 7B-2901. Confidentiality of records.**
  - (a) The clerk shall maintain a complete record of all juvenile cases filed in the clerk's office alleging abuse, neglect, or dependency. The records shall be withheld from public inspection and, except as provided in this subsection, may be examined only by order of the court. The record shall include the summons, petition, custody order, court order, written motions, the electronic or mechanical recording of the hearing, and other papers filed in the proceeding. The recording of the hearing shall be reduced to a written transcript only when notice of appeal has been timely given. After the time for appeal has expired with no appeal having been filed, the recording of the hearing may be erased or destroyed upon the written order of the court or in accordance with a retention schedule approved by the Director of the Administrative Office of the Courts and the Department of Natural and Cultural Resources under G.S. 121-5(c).
  - The following persons may examine the juvenile's record maintained pursuant to this subsection and obtain copies of written parts of the record without an order of the court:
    (1) The person named in the petition as the juvenile;
    (2) The guardian ad litem;
    (3) The county department of social services; and
    (4) The juvenile's parent, guardian, or custodian, or the attorney for the juvenile or the juvenile's parent, guardian, or custodian.

7 Keys for Coordinating with DSS Counties

*There are **7 key steps** that providers can take to better coordinate with DSS in support of serving FC youth*

1. Develop relationships with local child welfare agencies
2. Help caseworkers obtain medical records to provide proper visibility in the child's health needs
3. Support the scheduling of visits with children and teens in foster care shortly after entry into foster care and in accordance with other visit timeframes
4. Ensure the duration of the visit should reflect the more intense and complex health needs of the population
5. Communicate health needs and information to caseworkers in an appropriate and timely manner
6. Complete health forms and provide copies to the caseworker
7. Understand and make timely referrals for mental health evaluations, developmental or educational evaluations, and dental assessments as appropriate

Supporting Transition Age Youth to Adult Healthcare

- **Youth ages 16 and 17 in foster care, Voluntary Foster Care 18-21 Program**
  - These youth often face a range of experiences and challenges:
    - Experience of abuse, neglect or dependency
    - At higher risk for involvement with DJJ, homelessness, pregnancies
- **Trauma can impact developmental processes**
  - Trauma may lead to precocious development, or development that seems to be “fast
  - Forwarded” or beyond what may seem age-appropriate
  - Neurobiological challenges in response to chronic experiences of trauma and adversity
- **Trauma can have an impact on coping responses**
  - Experiencing aggression
  - Using substances
  - Engaging in self-harm or experiencing suicidality
  - Having problems with unhealthy relationships
  - Experiencing withdrawal and avoidance

Understanding Shared Parenting

Due to the nature of shared parenting for foster youth, multiple individuals may be involved in health visits, decisions, and supports

- **Shared Parenting Defined:** A practice in which foster parents/kinship parents/caretakers cultivate positive, supportive relationships with birth parents
- Promotes reunification efforts and maintains relationship between the child and birth family
- Birth parents may accompany DSS social workers or foster parents/kinship parents/caretakers to medical visits to maintain an understanding of and have a say in the children's medical needs

More Resources

Please reference the following links to learn more about the intersection between child welfare and health supports for foster care youth

- https://www.childwelfare.gov/pubpdfs/health_care_foster.pdf
- https://www.medicaid.gov/medicaid/quality-of-care/downloads/foster-care-webinar.pdf
- https://www.childwelfare.gov/pubPDFs/bulletins_youthsud.pdf
- https://cdn.ymaws.com/www.ncpeds.org/resource/collection/49A55DA6-14AA-44A9-BADC-1EA83939CC37/trauma-informed-guiding-principles-for-working-with-transition-age-youth-provider-fact-sheet.pdf

Medicaid Coverage & Supports for the Foster Care Population

Chameka Jackson, MSSA, LCSW
Child and Adolescent Services Coordinator
NC DHHS, Division of Health Benefits

FAQs About Medicaid Coverage for Foster Care Youth

WHAT HAPPENS IF A CHILD ENROLLED IN A HEALTH PLAN ENTERS FOSTER CARE?

Once the local Department of Social Services (DSS) Medicaid program is aware that a child has entered foster care, the Medicaid caseworker adds foster care evidence in NC FAST, NCDHHS' eligibility system.

- If a child is enrolled in a Standard Plan at the time they enter foster care, the child will be disenrolled from the Standard Plan and transitioned back to NC Medicaid Direct.
- When the child transitions to NC Medicaid Direct, the Standard Plan works with NC Medicaid Direct care management providers (see next slide) to coordinate the transition of care management, services, and supports.

WHAT IS THE HEALTH PLAN DISENROLLMENT PROCESS TIMELINE?

During the first month of the child's placement in foster care, Medicaid and Child Welfare staff coordinate to update the child's eligibility evidence in NC FAST.

- The new foster care evidence on the child's case will then trigger a change in their Managed Care Status in NC FAST (and NCTracks by the next Business Day)
- The child will then be flagged to receive Medicaid coverage under NC Medicaid Direct, **retroactive to the first day of the month** that the child entered foster care.
- Medicaid coverage can be made retroactive by up to **three (3) months** if medically necessary, removing the barrier to timely access to care.

HOW DOES THE HEALTH PLAN DISEROLLMENT PROCESS IMPACT HOW PROVIDERS SHOULD SUBMIT CLAIMS?

When seeing a foster care youth, providers can look up their eligibility in NCTracks and either bill the SP or NC Medicaid Direct.

- If you are not contracted with the PHP, you can still provide services and then wait to bill NC Medicaid Direct.
- If the child's caseworker is processing the Medicaid application for the first time, you can still provide services and then wait to bill NC Medicaid Direct.

Claims may be submitted up to **one year post the date that service was provided,** allowing time for foster care youth to transition back to NC Medicaid Direct.

Care Management Supports Under Medicaid Direct

Foster Care Youth are eligible to receive a full suite of care management services under NC Medicaid Direct that aim to help support their complete care needs throughout their time in foster care.

NC Medicaid Direct Care Management Overview			
	Physical Health Services		**Behavioral Health Services**
Program	Primary Care Case Management (PCCM)	Care Management for At-Risk Children (CMARC)	Prepaid Inpatient Health Plan (PIHP)
Service Entity	Community Care of North Carolina (CCNC)	Local Health Departments	Local Management Entity/Managed Care Organization (LME/MCO)
Delivery Model	Statewide	County Based	Regional
FC Populations Served	Foster Care Youth	Foster Care Youth Age 0 to Age 5	Foster Care Youth with a Diagnosis of BH, I/DD, TBI, SUD Needs
Key Services Provided	• Care Needs Screenings • Comprehensive Assessment • Transitional Care services (for PCCM and CMARC enrollees) • Care Plan development and support with health goal setting • Medication Management (for PCCM and CMARC enrollees) • Assistance with obtaining medical appointments, referrals, and DME • Service utilization monitoring • SDOH need identification and resource linkage. • Collaboration with LME/MCO care coordinators for children needing intensive BH services.	• Care Plan development and support with health goal setting • Assistance with obtaining medical appointments, referrals, and DME • Service utilization monitoring • Developmental Screenings with members who have been referred for adverse childhood experiences (ACE's) or Toxic Stress • Face to Face visits • Foster Care Referrals • Plan of Safe Care (POSC) referrals • Neonatal Intensive care unit referrals • SDOH need identification and resource linkage	• Transitional Care Assessment • Educate and connect enrollees to clinically relevant mental health, I/DD, TBI, and SUD services and supports • Coordinate Behavior Health specialist appointment setting and referrals • Provide 24/7 Behavioral Health Crisis Support
Link to Learn More	https://www.communitycarenc.org	https://medicaid.ncdhhs.gov/transformation/care-management/care-management-risk-children-cmarc	https://www.ncdhhs.gov/providers/lme-mco-directory

Health Priorities for Foster Care Youth

To address the unique needs of the foster care population, we encourage the provider community to prioritize the following elements of care delivery:

- ✓ **T**imely access to care
- ✓ **E**arly and often evaluation of care needs
- ✓ **A**ppropriate medication management
- ✓ **M**ental and Behavioral health needs considered at each touchpoint
- ✓ **S**trong education about available health services and supports

Helpful Medicaid Resources

Please reference the following Managed Care Provider resources to learn more or find help for any additional questions about Medicaid policies, programs, and resources.

Foster Care Fact Sheets
Medicaid Foster Care fact sheets provide further detail about Medicaid rules and guidelines around the foster care population.

NC Medicaid Bulletin Articles
Medicaid provider bulletin articles give providers the latest information on all Medicaid topics. Providers can also sign up to receive email updates from NCTracks.

NC Medicaid Managed Care Provider Playbook
Where providers can access the latest information, tools and other resources to help you and your patients smoothly transition to NC Medicaid Managed Care. Visit the Provider Playbook often as resources will be added as they become available.

NC Medicaid Managed Care Provider Webinars
The latest schedule, registration and information about previous webinars are available on the AHEC Medicaid Managed Care website.

NC Help Center Available for Providers to Find Information
The NC Medicaid Help Center is an online source of information about Managed Care, COVID-19 and Medicaid and behavioral health services, and is also used to view answers to questions from the NC Medicaid Help Center mailbox, webinars and other sources. To use this new tool:

1. Go to NC Medicaid Help Center
2. Type a topic or key words into the search bar
3. Select a topic from the available list of categories

Detailed information about the NC Medicaid Help Center is available in a Medicaid Bulletin.

Best Practices for Treating Children/Youth in Foster Care

Christy Street, MSW
Director, Fostering Health NC

- **Special health care needs of children in FC**
- **AAP Guidelines and Best Practices**
- **Child Welfare Policy & AAP Guidelines**
  - Tips around appointments
- **Billing & Coding Information**
- **How trauma should be assessed & considered in treatment plans**

The “Why”

- Children and youth in foster care have often had episodic, fragmented and/or inadequate healthcare.
- Children and youth in foster care have a high prevalence of health problems and often multiple transitions that can adversely impact their health and well-being.
- Children and youth in foster care also have high rates of behavioral health concerns and many are prescribed psychotropic medications
- The American Academy of Pediatrics has designated them **Children and Youth with Special Health Care Needs** which means they require specialized care

Children and youth in foster care should be seen EARLY and OFTEN

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Key AAP Guidelines

- AAP recommends that within 30 days of placement, children and youth in foster care have the following detailed, comprehensive evaluations:
  - A mental health evaluation
  - A developmental health evaluation if under age 6
  - An educational evaluation, if over age 5
  - A dental evaluation

- These evaluations can be conducted as part of the comprehensive health assessment by a multi-disciplinary team or through referrals to specialists.

- Timely completion of these evaluations is important as well as information sharing among all the professionals and caregivers caring for the child or youth. Information from these assessments should be shared with child welfare to ensure that it is incorporated into permanency planning for the child or youth.

What Does Children & Youth with Special Health Care Needs Mean?

- Defined as those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions & who also require health and related services of a type or amount beyond that required by children generally.

- Includes children with:
  - Chronic physical problems (e.g., asthma, sickle cell disease,
  - hearing loss)
  - Developmental concerns and conditions
  - Behavioral health concerns and conditions
  - History of premature birth and/or prenatal substance exposure
  - Complex needs and those who are medically fragile

- And this includes children who have experienced TRAUMA

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Children in foster care, *no matter how healthy they seem*, are considered to be Children and Youth with Special Health Care Needs.

Role of Pediatrics in Care of Children with Exposure to Trauma, Adverse Childhood Experiences, and/or Adversity

Pediatricians are uniquely positioned to intervene through their:

- Regular interactions with children
- Appreciation for the important role that families and communities play in determining child wellness
- Developmental approach to health
- Understanding of the advantages of prevention over remediation
- Awareness of the critical importance of effective advocacy to promote changes in well-established systems that influence health and development

- Persistent health disparities associated with poverty and child maltreatment could be reduced by the treatment and alleviation of ACEs in childhood.

Information from: “Helping Foster and Adoptive Families Cope With Trauma.” American Academy of Pediatrics and vetoviolence.cdc.gov

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American Academy of Pediatrics (AAP) Guidelines

- AAP Recommendations/Guidelines include:
  - An Initial Health Screening visit within 72 hours of entering foster care
  - A Comprehensive Health Visit within 30 days of placement
  - A Follow-up Health Visit within 60-90 days of placement
  - An enhanced visit schedule, based on age
    0-6 months of age - visits monthly
    6-24 months of age - visits every 3 months
    2-21 years of age - visits twice per year

Website www.aap.org/fostercare

Healthy Foster Care America

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Purpose of Initial Health Screening

- Ideally, all past relevant medical records would be available for this visit. In practice, however, many children may be placed without these records & should be seen despite the incomplete medical history.

- This should be a brief visit

Purpose is:

- To identify health conditions that require prompt medical attention such as:
  - acute illnesses
  - chronic diseases requiring intervention such as medications, testing, or devices
  - signs of abuse or neglect
  - signs of infection or communicable diseases
  - hygiene or nutritional problems
  - pregnancy
  - significant developmental or mental health disturbances

- To identify health conditions that should be considered in making future placement decisions

Purpose & Components of the Comprehensive Health Visit

- To review available health information and medical history about the child or youth
- To identify and treat medical conditions
- To identify developmental and mental health conditions requiring immediate attention
- To complete age appropriate screenings
- To develop an individualized treatment plan

Purpose of Follow-up Visit & Enhanced Visit Schedule

- To promote overall wellness
- To identify problems & concerns through periodic history, examination, & screenings
- To provide education related to the child's condition or issues of concern to foster parents
- To update immunizations
- To review findings from developmental &/or mental health assessments
- To refine & reinforce treatment plan (These visits provide an opportunity for the provider to meet with the SW, caregiver(s), and birth parent(s), when appropriate, to review findings & promote integration into the permanency plan.)
- To provide age-appropriate anticipatory guidance on a regular basis to children/youth, foster/resource, and birth parents

AAP and NC Child Welfare Policy

There are differences in AAP standards & what is required per state policy – here is a snapshot:

Source	Initial Screening	Comprehensive Visit	Subsequent visits/Schedule	Comprehensive Evaluations
AAP	Within **72 hours** of entering foster care	Within 30 days	**Age-based enhanced schedule:** **0-6 mos: monthly** **6-24 mos: visits every 3 mos** **2-21 years: visits every 6 mos**	Within 30 days of placement, children/teens in FC care should have the following detailed, comprehensive evaluations:: • Mental Health evaluation • Developmental health eval if under age 6 years • Educational eval if over age 5 years • Dental evaluation
Child Welfare Policy	Within **7 days** of Entering foster care	Within 30 days	Physical exam at least every 12 months, **or more frequently as recommended by the medical provider**	Within 30 days of entry into FC, children must have the following comprehensive evaluations **scheduled**: • Mental health evaluation, with ongoing monitoring & assessment as needed • Developmental health eval if under the age of 6, with ongoing monitoring & assessment as needed • Educational eval if over the age of 5 • Dental evaluation (NOTE: if known, this should be based on the last time the child had a dental evaluation). If, after assessing the child, 1 or more of the above evals are determined to be not needed, documentation as to why must be provided.

Although the AAP recommendations are not "required", FHNC does recommend & promote them and provides this education and information to primary care providers so they can promote and follow those guidelines.

This point is made for clarification regarding "requirements" from a monitoring perspective and what is best practice and what to aim for in regard to comprehensive care for children in foster care.

Billing and Coding

In general, practices will need to use principles of coding for patients with **complex conditions** for visits for children and youth in foster care. This is due to the higher likelihood of developmental, behavioral, chronic physical health, and oral health issues.

Except for the Initial Visit, it is reasonable to expect these visits to take a longer amount of time.

It is also useful to use the Z-code for **foster care status Z62.21 (listed as another diagnosis code that is not the primary code)** as it helps to support the complexity of the E&M code and the higher payment associated with that code. It also provides a way to **use billing data to generate lists for population management.**

The Comprehensive Visit meets criteria for a consult, even if the child was already a patient. DSS is requesting the assessment & the PCP is producing a report that synthesizes information from historical records, screenings, & the physical exam. The report includes recommendations for DSS for use in future planning for the child. Documenting that DSS requested the consult & completing the forms for the report meets consult criteria**.** The consult code payment, (plus the prolonged visit code if indicated due to time), justifies the time for the visit.

See Billing and Coding Guidance – Foster Care Visit Options and Codes document on Fostering Health NC Resource Library.
This information does not take the place of NC Medicaid guidelines.
www.ncpeds.org/fhnclibrary

Screenings

Screening for developmental, social-emotional, and mental health, as well as follow-up and referral to appropriate services or treatment are very important aspects of pediatric care.

Children in foster care should receive the same well-child screenings recommended by the NC Health Check Billing Guide and Bright Futures for children who are not in foster care, which include screening for primary general health risks and strengths.

Children in foster care are at high risk for social-emotional delay due to trauma and exposure to toxic stress. Social-emotional development is impacted early and, if ignored, can lead to long term problems with health and behavior. All children in foster care should have a validated social-emotional screening as well as comprehensive mental health evaluation for a positive screening or known mental health condition.

See Healthy Child and Adolescent Development document on Fostering Health NC Website.
www.ncpeds.org/fhnclibrary

See Bright Futures as well as NC Health Check Billing Guide for detailed information on screenings and assessments.

Care Management Service for Foster Children

Kimberly DeBerry, Maternal Child Health Director

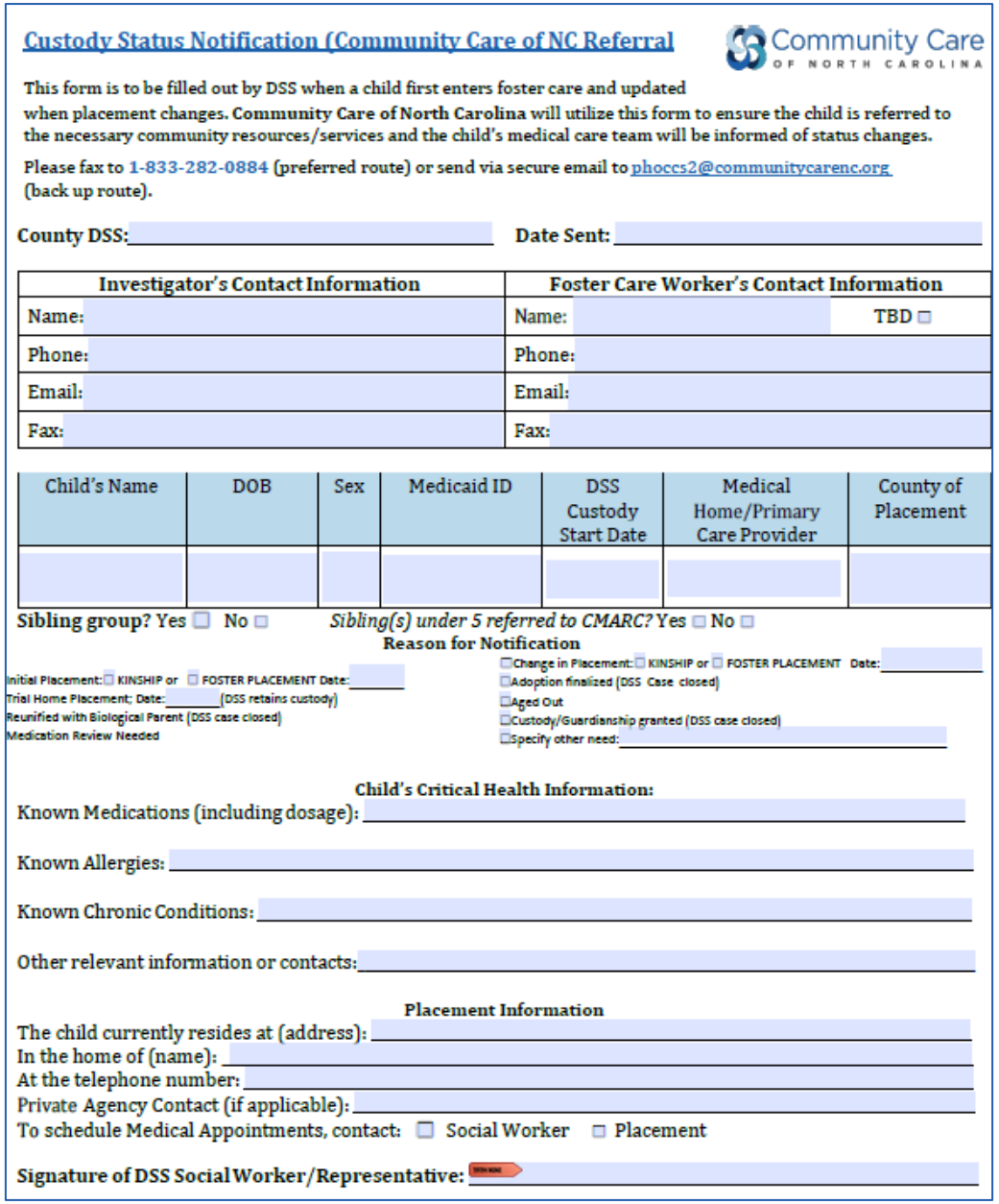
Care Management Services

- Statewide reach to ensure continuity of care during placement changes.
- Risk Stratification methodology to align intensity of care management.
- Care Needs Screening to determine needs and intensity of care management.
  - Children ages 0-5 with no complex needs and not prescribed medication are referred to Care Management for At-Risk Children (CMARC).
- Complete comprehensive assessment and use the results to develop a care plan for high-risk children.
- Comprehensive management of physical, BH, pharmacy, and resource needs.
- Medication management in accordance with recognized professional guidelines.
  - Ensure adequate supply
  - Monitor Psychotropic medication use.
  - Coordinate with member's PCP and pharmacy to ensure access to prescriptions and adjust the regimen appropriately.
  - Leverage CCNC pharmacist expertise as needed.

Care Management Services

- Notify DSS, parents(s), guardians(s) and custodian(s), as appropriate, of a change in health plan.
- Provide transition and diversion activities to identify and engage members who may be able to have their needs met in the community, ensure the availability of appropriate services following discharge.
- Provide transitional care management between plans & treatment settings if made aware.
  - Connect with the member after transition/discharge
  - Facilitate clinical warm handoffs
  - Arrange for medication management after discharge
- Collaboration with other stakeholders, such as the LME-MCO in order to obtain assistance with higher intensity behavioral health services and placement.

Custody Status Notifications for the Provider



Custody Status Notification (Community Care of NC Referral

Community Care OF NORTH CAROLINA

This form is to be filled out by DSS when a child first enters foster care and updated when placement changes. **Community Care of North Carolina** will utilize this form to ensure the child is referred to the necessary community resources/services and the child's medical care team will be informed of status changes.

Please fax to 1-833-282-0884 (preferred route) or send via secure email to phoccs2@communitycarenc.org (back up route).

County DSS: _____ **Date Sent:** _____

Investigator's Contact Information	Foster Care Worker's Contact Information
Name:	Name: TBD ☐
Phone:	Phone:
Email:	Email:
Fax:	Fax:

Child's Name	DOB	Sex	Medicaid ID	DSS Custody Start Date	Medical Home/Primary Care Provider	County of Placement

Sibling group? Yes ☐ No ☐ *Sibling(s) under 5 referred to CMARC?* Yes ☐ No ☐

Reason for Notification

Initial Placement: ☐ KINSHIP or ☐ FOSTER PLACEMENT Date: _____
Trial Home Placement; Date: _____ (DSS retains custody)
Reunified with Biological Parent (DSS case closed)
Medication Review Needed

☐ Change in Placement: ☐ KINSHIP or ☐ FOSTER PLACEMENT Date: _____
☐ Adoption finalized (DSS Case closed)
☐ Aged Out
☐ Custody/Guardianship granted (DSS case closed)
☐ Specify other need: _____

Child's Critical Health Information:

Known Medications (including dosage): _____

Known Allergies: _____

Known Chronic Conditions: _____

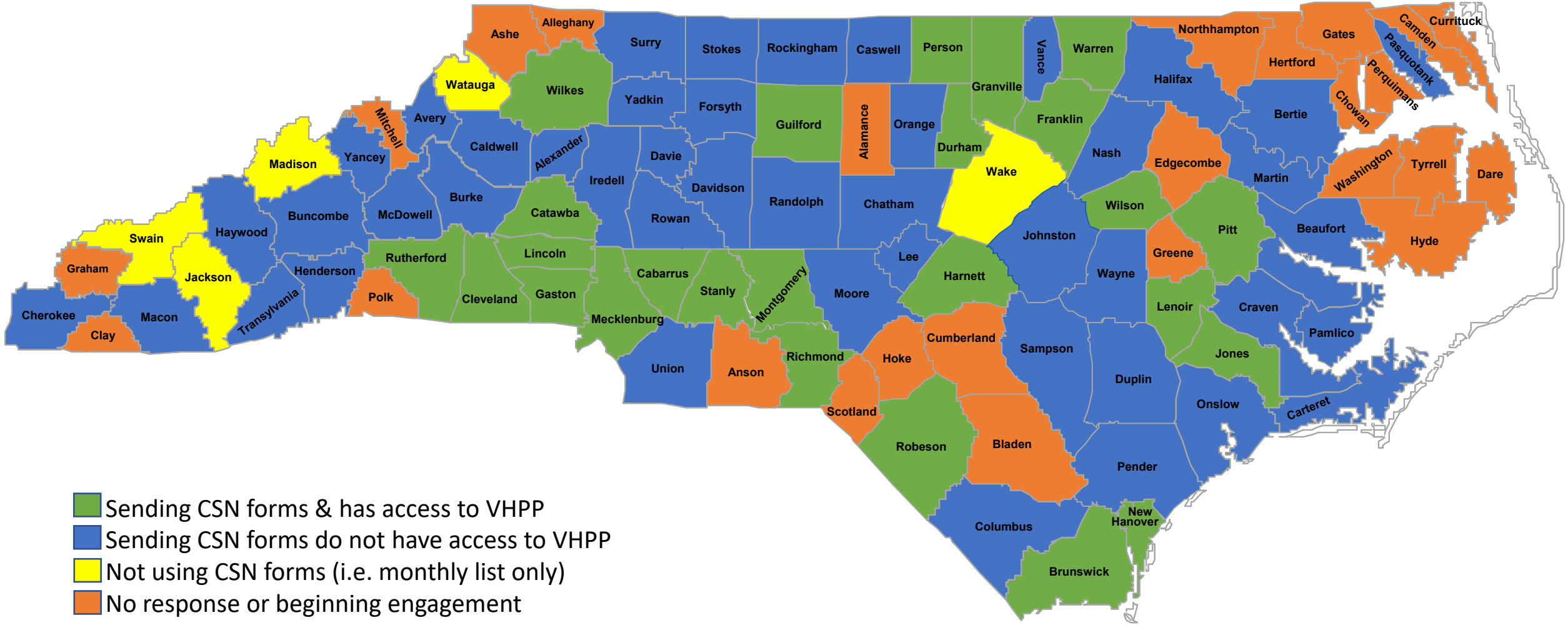
Other relevant information or contacts: _____

Placement Information

The child currently resides at (address): _____
In the home of (name): _____
At the telephone number: _____
Private Agency Contact (if applicable): _____
To schedule Medical Appointments, contact: ☐ Social Worker ☐ Placement

Signature of DSS Social Worker/Representative: _____

Community Care
OF NORTH CAROLINA



- Sending CSN forms & has access to VHPP
- Sending CSN forms do not have access to VHPP
- Not using CSN forms (i.e. monthly list only)
- No response or beginning engagement

Provider Foster Care Notification

Community Care
OF NORTH CAROLINA

Practice Name: Date:

This child has entered **foster care**, in the custody of DSS and is currently or has recently been assigned to your practice for their primary medical care.

Child's Name:	Date of Birth:
DSS Social Worker:	Contact:
Care Management Team Member:	Contact:
Foster Parent:	Contact:

Pertinent information received from DSS:

Due to the child's involvement in child welfare, we ask that the current American Academy of Pediatrics (AAP) recommended standards of care for children and youth in foster care be followed.

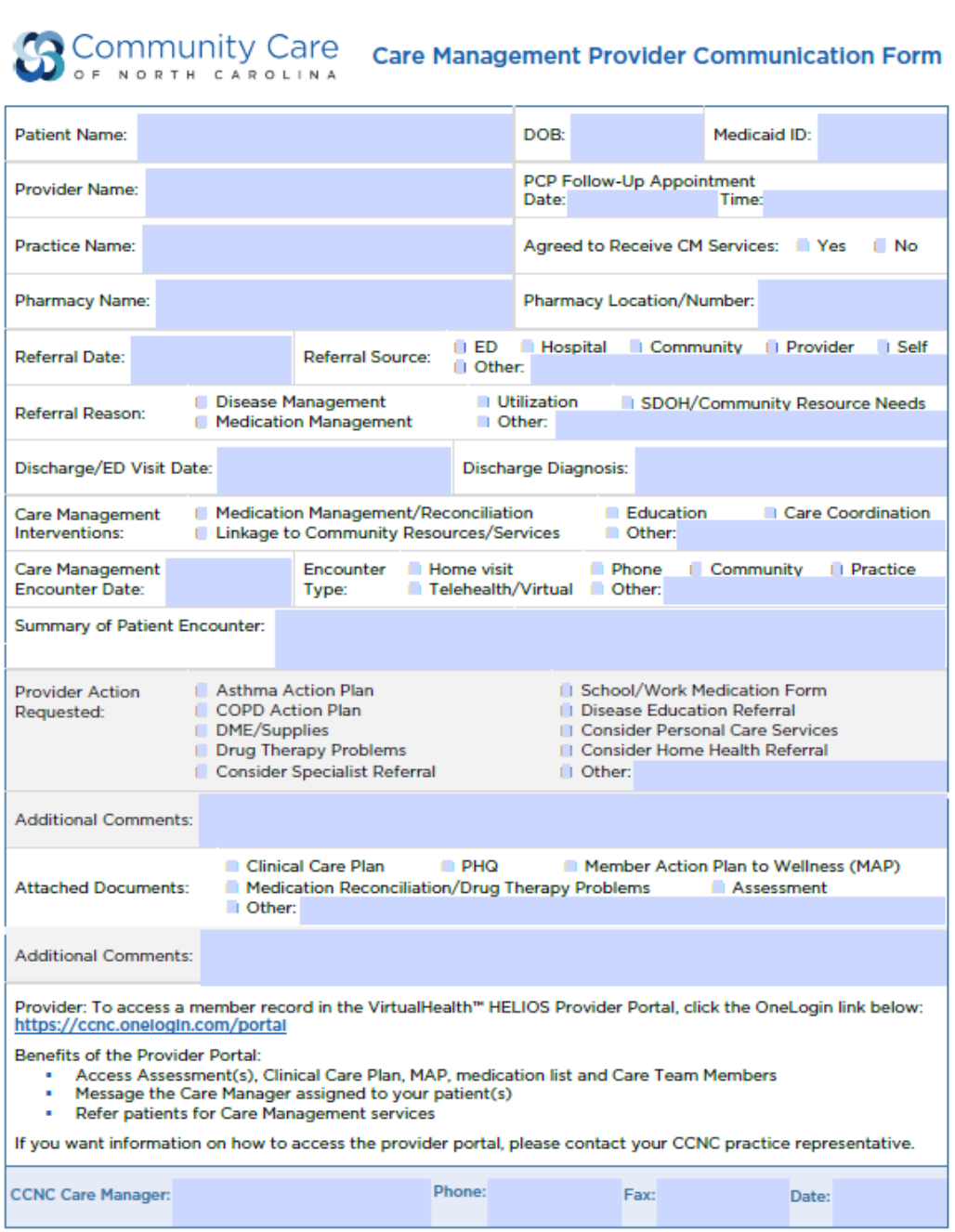
Initial Visit: This visit should occur **within 72 hours of placement into foster care**. This is a quick visit, meant to last about 15 minutes. The initial visit is an assessment of acute care needs focused on health conditions requiring prompt attention, including any prescription refills that are needed.

Comprehensive Visit: This second visit should occur **within 30 days of placement into foster care** unless it is medically necessary to see the child sooner. *Prior to this visit, DSS should send the practice a health history form, which outlines the child's health, placement, and educational history in greater detail.* This visit is an opportunity to identify developmental and behavioral health conditions, complete dental and other age-appropriate screenings, and develop an individualized care plan to be shared with those responsible for the child's care and well-being.

Follow-Up Well-Visits: **These visits begin within 60-90 days of placement** and are focused on primary and preventative health care services. The AAP standards for these visits are as follows:

- **0-6 months of age**: Should be seen every month
- **6-24 months of age**: Should be seen every 3 months
- **2-21 years of age and times of significant change** (e.g., change in placement, reunification): Should be seen every 6 months

Important Notes: Each of these visits has an accompanying Health Summary Form for the provider to complete. These forms can be downloaded from the Fostering Health NC Online Library under the "Health Forms" tab at http://www.ncpeds.org/?page=FHNCLibrary or a copy can be requested from your local DSS office. **These forms should be sent back to DSS within five days of the visit.** Importantly, providers may substitute Electronic Medical Record (EMR) printouts for Health Summary Forms (or combinations of each) so long as the required elements of information are included. For more information about these visits and how to code for them, please see "A Framework for Foster Care Visits" also available in the online library: https://bit.ly/fstcre.



Community Care OF NORTH CAROLINA

Care Management Provider Communication Form

Patient Name:		DOB:		Medicaid ID:	
Provider Name:		PCP Follow-Up Appointment Date:		Time:	
Practice Name:		Agreed to Receive CM Services:	☐ Yes ☐ No		
Pharmacy Name:		Pharmacy Location/Number:			
Referral Date:		Referral Source:	☐ ED ☐ Hospital ☐ Community ☐ Provider ☐ Self ☐ Other:		
Referral Reason:	☐ Disease Management ☐ Medication Management	☐ Utilization ☐ Other:	☐ SDOH/Community Resource Needs		
Discharge/ED Visit Date:		Discharge Diagnosis:			
Care Management Interventions:	☐ Medication Management/Reconciliation ☐ Linkage to Community Resources/Services	☐ Education ☐ Other:	☐ Care Coordination		
Care Management Encounter Date:		Encounter Type:	☐ Home visit ☐ Telehealth/Virtual	☐ Phone ☐ Other:	☐ Community ☐ Practice
Summary of Patient Encounter:					
Provider Action Requested:	☐ Asthma Action Plan ☐ COPD Action Plan ☐ DME/Supplies ☐ Drug Therapy Problems ☐ Consider Specialist Referral	☐ School/Work Medication Form ☐ Disease Education Referral ☐ Consider Personal Care Services ☐ Consider Home Health Referral ☐ Other:			
Additional Comments:					
Attached Documents:	☐ Clinical Care Plan ☐ PHQ ☐ Member Action Plan to Wellness (MAP) ☐ Medication Reconciliation/Drug Therapy Problems ☐ Assessment ☐ Other:				
Additional Comments:					

Provider: To access a member record in the VirtualHealth™ HELIOS Provider Portal, click the OneLogin link below:
https://ccnc.onelogin.com/portal

Benefits of the Provider Portal:
- Access Assessment(s), Clinical Care Plan, MAP, medication list and Care Team Members
- Message the Care Manager assigned to your patient(s)
- Refer patients for Care Management services

If you want information on how to access the provider portal, please contact your CCNC practice representative.

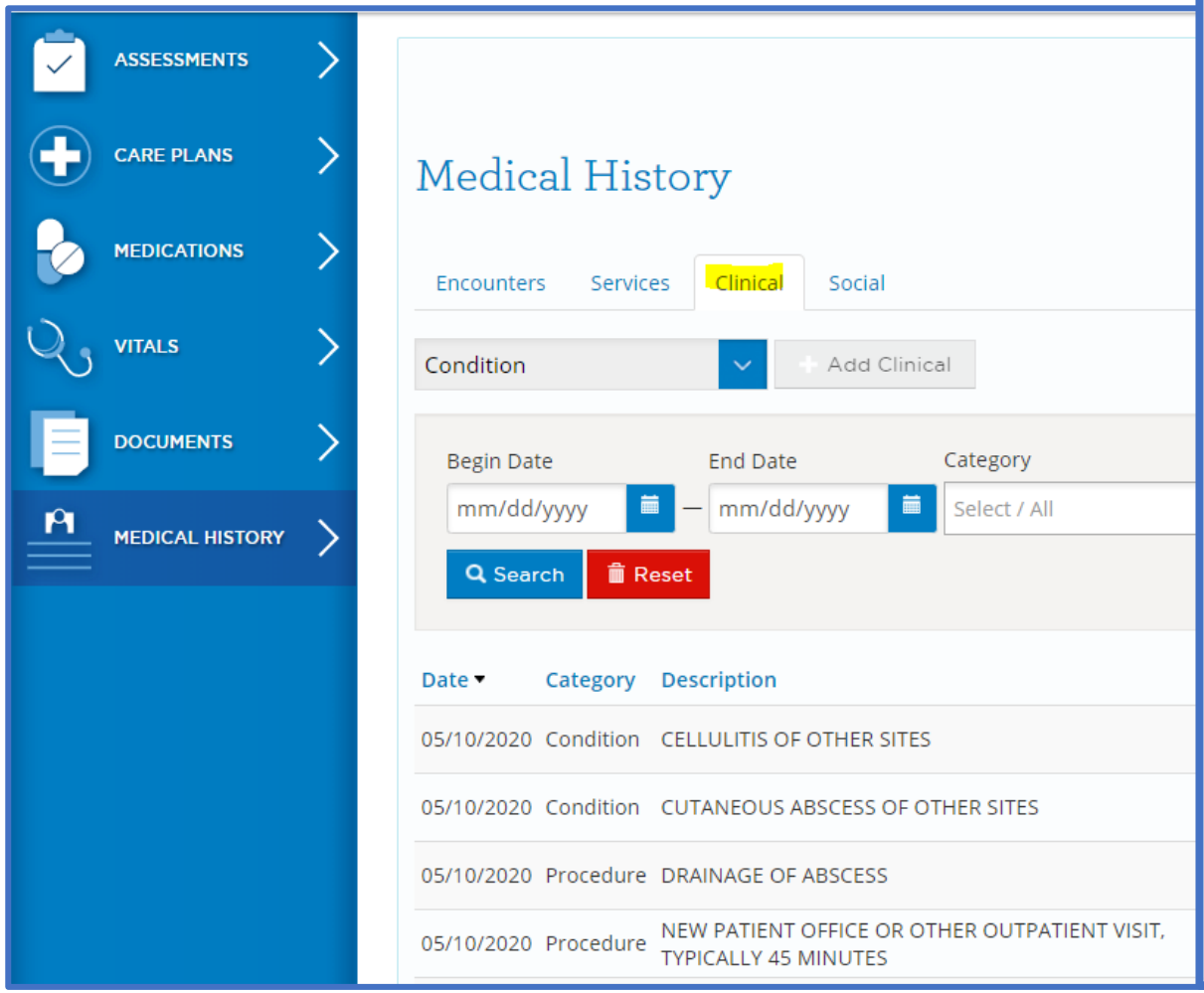
CCNC Care Manager:		Phone:		Fax:	Date:

For individuals prescribed one (1) or more antipsychotic medications, the care manager will recommend appropriate metabolic monitoring using the Provider Communication Form.

"This member is currently prescribed an antipsychotic medication, please consider metabolic monitoring as appropriate."

Metabolic Monitoring Provider Notification

VirtualHealth Provider Portal- Condition and Visit History



Visit

Visit Date:	03/10/2020
Type:	Other
Description:	HEALTH CHECK - OTHER PROVIDER, UNDER 21
Facility / Location:	French Broad Pediatric Associates P
Place of Service:	OFFICE
Provider:	
Specialty:	
Notes:	Claim Source: DMA
Submitted By:	Admin, System (Administrator)

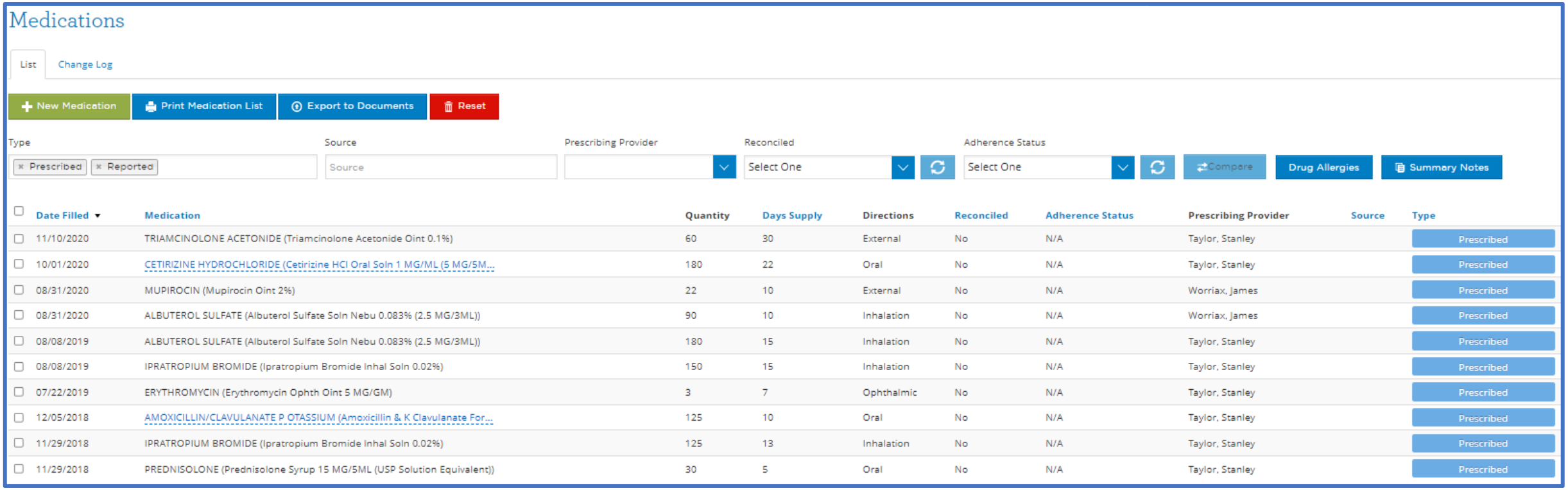
Condition(s)

Date Diagnosed or Reported	Code	Name
03/10/2020	J309	ALLERGIC RHINITIS, UNSPECIFIED
03/10/2020	J45909	CHILD IN WELFARE CUSTODY
03/10/2020	P0730	ENCOUNTER FOR IMMUNIZATION
03/10/2020	Z00129	ENCOUNTER FOR ROUTINE CHILD HEALTH EXAMINATION ...
03/10/2020	Z23	PRETERM NEWBORN, UNSPECIFIED WEEKS OF GESTATION
03/10/2020	Z6221	UNSPECIFIED ASTHMA, UNCOMPLICATED

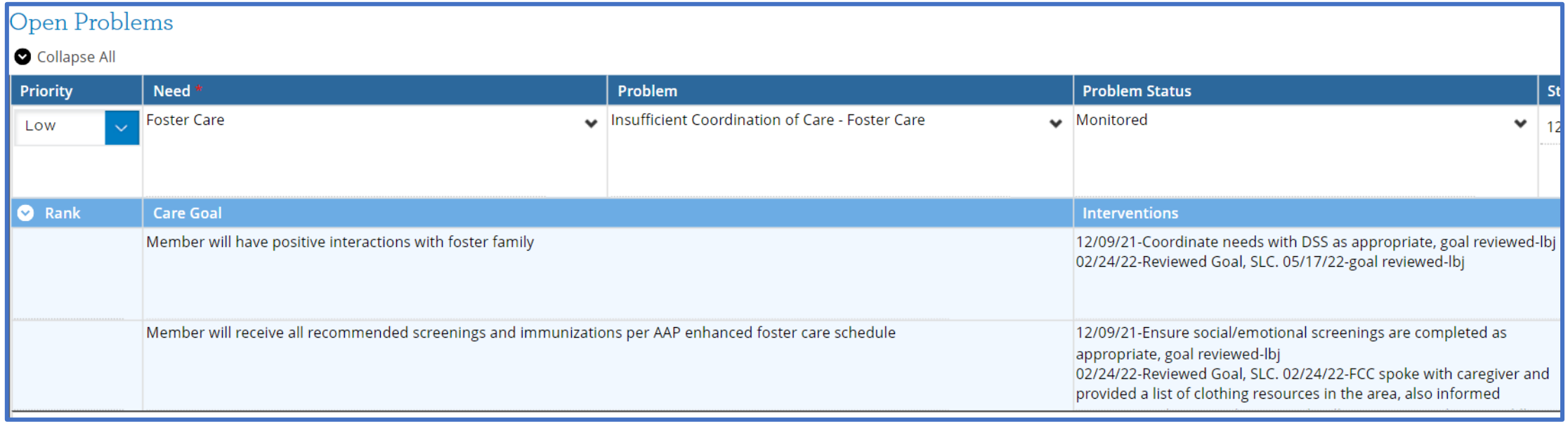
Procedure(s)

Procedure Date	Code	Name	Place of Service
03/10/2020	90471		OFFICE
03/10/2020	99203		OFFICE

VirtualHealth Provider Portal- Medications



VirtualHealth Provider Portal- Care Plan



Open Problems

Collapse All

Priority	Need *	Problem	Problem Status	St
Low	Foster Care	Insufficient Coordination of Care - Foster Care	Monitored	12

Rank	Care Goal	Interventions
	Member will have positive interactions with foster family	12/09/21-Coordinate needs with DSS as appropriate, goal reviewed-lbj 02/24/22-Reviewed Goal, SLC. 05/17/22-goal reviewed-lbj
	Member will receive all recommended screenings and immunizations per AAP enhanced foster care schedule	12/09/21-Ensure social/emotional screenings are completed as appropriate, goal reviewed-lbj 02/24/22-Reviewed Goal, SLC. 02/24/22-FCC spoke with caregiver and provided a list of clothing resources in the area, also informed

Provider Referrals & Resources

- Before contacting the caregiver, we must have DSS consent. This may cause a delay in services.
- https://www.communitycarenc.org/what-we-do/clinical-programs/pediatrics/tools/foster-care

Community Care OF NORTH CAROLINA

Care Management for Children and Youth in Foster Care

Community Care of North Carolina (CCNC) is contracted by NCDHHS to provide care management services to children and youth in foster care. CCNC has a foster care team that works closely with healthcare providers, local departments of social services, foster families, foster home placements, other care management agencies, and Fostering Health NC to coordinate care and improve the health and well-being for children and youth in foster care. This team approach allows us to better reach our goal of ensuring children are healthy, safe, and thriving.

Care Management can:

- Coordinate with DSS staff as children come into foster care custody. Assess and offer support to address urgent medical needs, emergency appointments, medication needs, and medical equipment needs.
- Ensure foster parents are aware of the child's health history and provide education on medical conditions, medications, red flags, use of medical equipment, and planning for the child's care needs.
- Support continuity of care by encouraging use of a medical home with a Primary Care Provider (PCP). Care Managers can assist with getting children connected to a Primary Care Provider and other needed services.
- Facilitate information sharing between DSS staff, medical providers, foster families, and/or biological parents.
- Assist caregivers in navigating the medical and behavioral health system and removing barriers to getting the care that is needed.
- Coordinate with Care Managers across the state when children are moved to a foster home outside their home county. Link DSS to Care Managers who know services and resources in the child's new community.

For more information visit:

https://www.communitycarenc.org or
https://www.ncpeds.org/page/FHNC

Transition of Care: Members Who Age out at Age 26

At least six months prior to the former foster child's 26th birthday:

- Assess and educate the member on options for obtaining health insurance coverage after their twenty-sixth (26th) birthday.
- Discuss the need for the member to create a plan to transition their healthcare, dental, and vision services as applicable, and medications to their chosen sources for these services.
- Screen for Advance Directive and POA knowledge. Share information if not in place and interested.
- Complete Care Needs Screening, if needs are identified, refer to care management for full assessment.
- Address care gaps.

Success Stories

- Foster parent called panicking on a Friday stating 2-year-old with a double ear infection, medication cost $400 that Medicaid would not cover it. After research found that member lives close to a state line and had taken the child to a provider in South Carolina. FCC found there were numerous providers in the office and located one with North Carolina NPI, then worked with NC pharmacy to coordinate stitching the prescription to the physician with the NC NPI to authorized medication for payment.

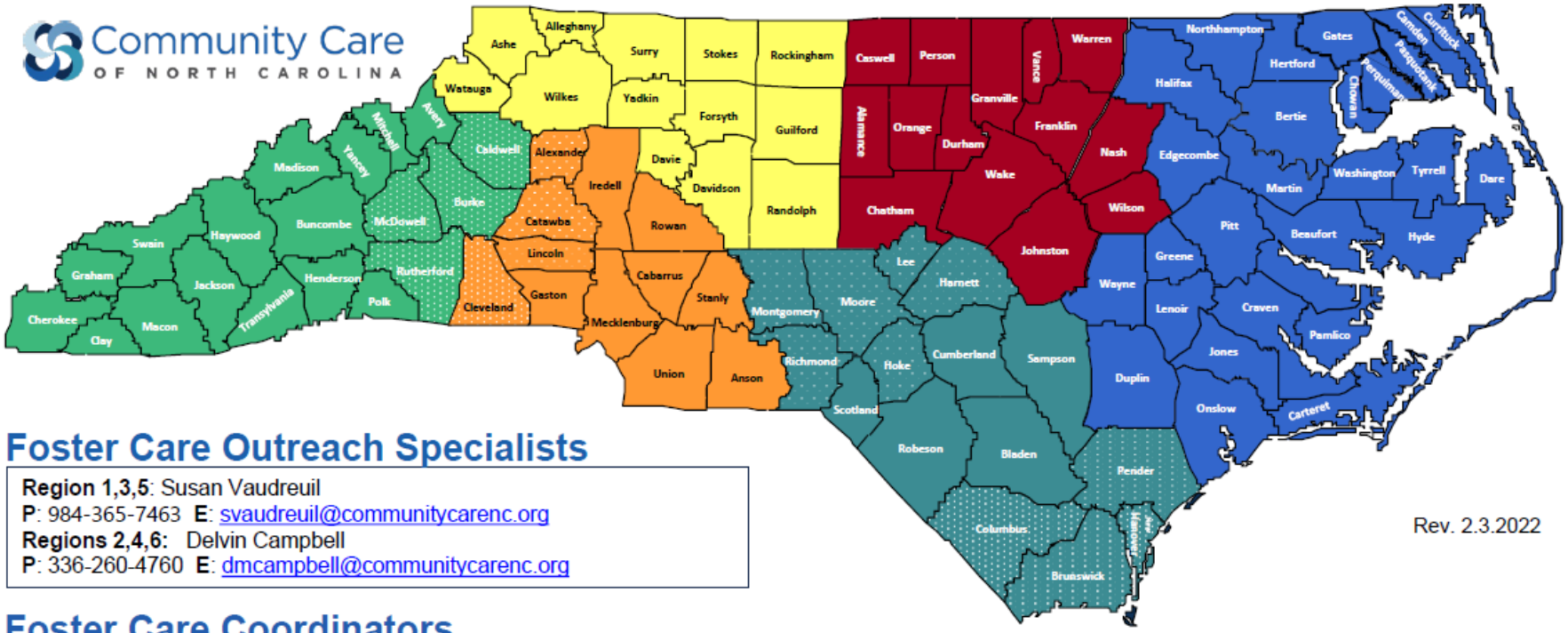
- Foster child discharged from an involuntary commitment after 2 weeks, placed in a home on a Thursday with enough psychotropic medication to last until Monday. BH appointment is scheduled 20 days out. The complex care manager reached out to the discharging physician who was unavailable, the PCP was not comfortable prescribing the medications because an evaluation had not been completed by their office. The CM researched the previous medication management provider to request a bridge prescription until member could attend appt. with the new BH provider. Saved an ER visit.

Success Stories

- DSS FCSW notified complex CM that 16-year-old birth controls were denied by Medicaid and requested the CM to assistance the foster parent with getting medication approved. After research CM found that the member was listed as a male and the pharmacy had the wrong MID#.

- FCC identified multiple chronic conditions and frequent ED visits via claims review. The caregiver was a family friend and was unaware of the medical conditions. FCC provided dx and medication education, dates last seen by the numerous specialist and upcoming appt information. Caregiver was very receptive. When following up with DSS, the FCSW was also unaware of the chronic conditions and was concerned that the caregiver did not have the experience to handle the child's complex needs and considered moving the member to a licensed foster home. FCC asked if the placement could be maintained for a week with intense CM following, DSS agreed. After 1 week, DSS FCSW decided to leave the member in the current placement as the caregiver was "one the ball" with getting things done. Additional disruption prevented.

Community Care
OF NORTH CAROLINA



Rev. 2.3.2022

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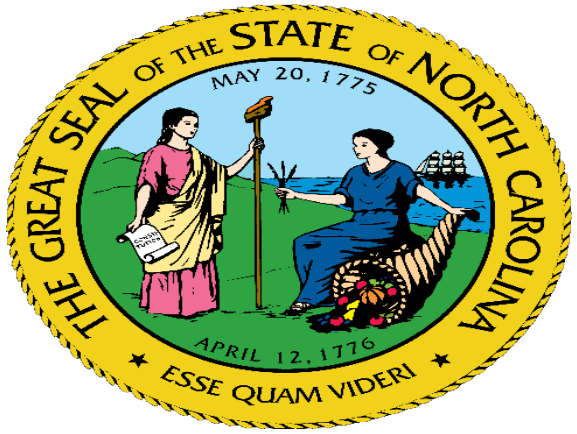
Community Care
OF NORTH CAROLINA



NC Department of Health and Human Services

CMARC Services for Children in Foster Care

Ginger Wilder BSN, RN, CCM
CMARC Program Manager

June 09, 2022

What is Care Management for At-Risk Children (CMARC)?

- A set of **early childhood care management** (CM) services for **at-risk children in a specific target population** ages **zero-to-five years**

- Usually provided by local health departments (LHDs) with support & guidance from NC Division of Public Health (DPH)

- Identifies the child's and family's needs by ongoing assessments and then "promotes the medical home, linkage to community resources, and provides information support to families" in order to meet the identified needs and **improve health outcomes for the child**

Outreach

The CMARC **Target Population** includes **children from birth to five years**:

- With special health care needs, as children who have or are at increased risk of having a serious or chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age; children in foster care are considered Children with Special Health Care Needs (CSHCN).
- Who were hospitalized in the **neonatal intensive care unit** (**NICU)**
- Who may have been exposed to **adverse childhood experiences (ACEs) or toxic stress,** which includes children in **foster care**
- Who are identified as **Priority Patients** by the Health Plans (HP's)

Note: Children in foster care are often referred for CMARC services by medical homes & community partners, but are also identified by Community Care of North Carolina (CCNC) based on info from the Department of Social Services (DSS)

CMARC Referral Screening Form available from the local health department CMARC program

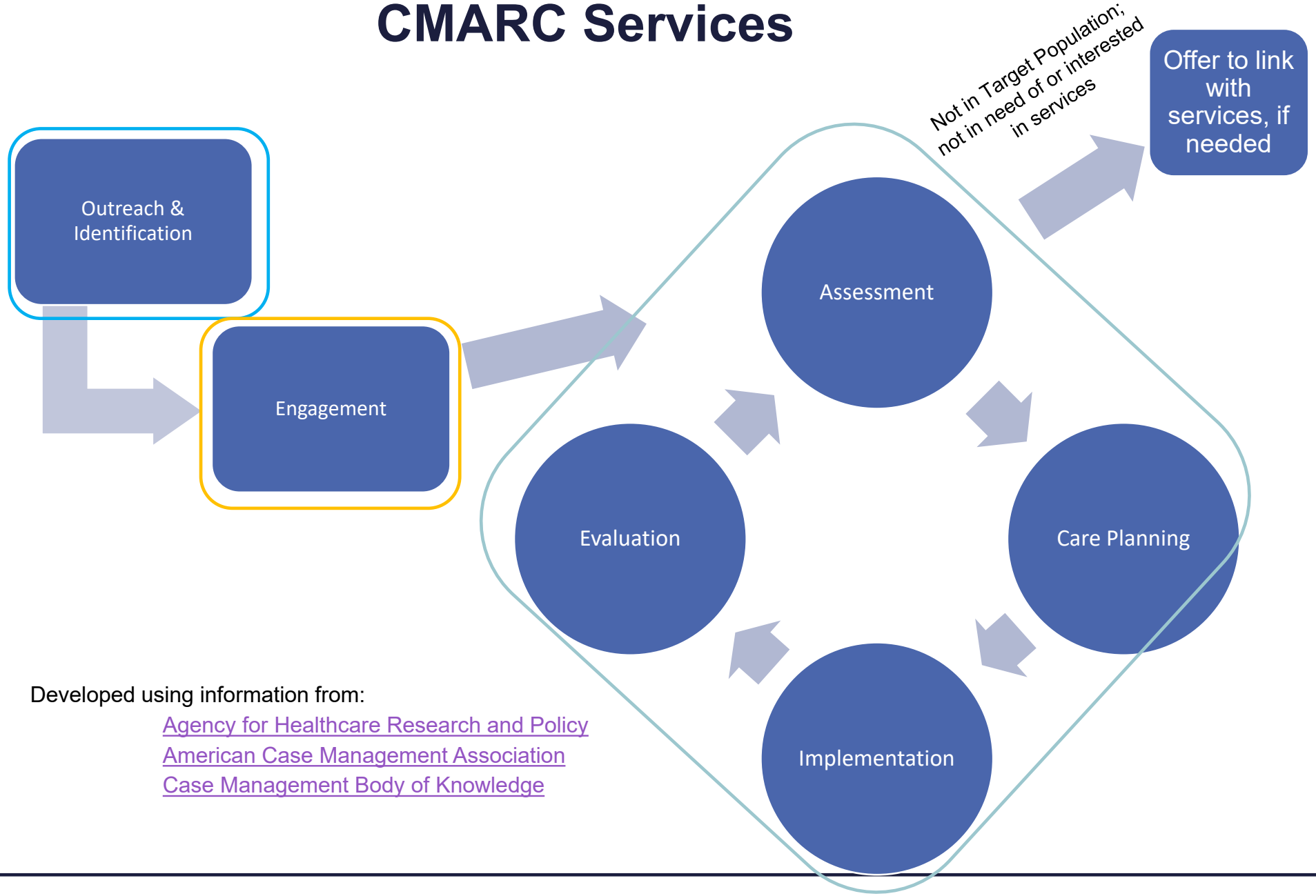
Children Exposed to ACEs or Toxic Stress

Situations contributing to toxic stress include:

- Children in foster care
- History of abuse or neglect
- Caregiver unable to meet infant's health and safety needs/neglect
- Parent(s) has history of parental rights termination
- Parental/caregiver/household substance abuse, neonatal exposure to substances
- Child Protective Services (CPS) Plan of Safe Care referral for "Substance Affected Infant"

- Child exposed to family/domestic violence
- Unsafe where child lives/environmental hazards or violence
- Incarcerated family or household member
- Parent/guardian suffers from depression or other mental health condition (e.g., maternal postpartum depression)
- Homeless or living in a shelter
- The presence of needs related to social determinants of health (SDOH) can result in toxic stress

CMARC Services



Developed using information from:

Agency for Healthcare Research and Policy
American Case Management Association
Case Management Body of Knowledge

CMARC Services to Children in Foster Care

Assessments include:

- **Survey of Well-Being of Young Children (SWYC)**
  - Consists of different tools that look at development, behavior and stress in the child's family environment
  - Required to be administered upon engagement and thereafter per the North Carolina's Periodicity Schedule
- **Comprehensive Needs Assessment (CNA)**
  - Gathers information about a member's conditions, diagnoses, needs and symptoms, as well many other factors that impact health including, cultural, social determinants and living status; the medical home status and frequency of visits is also assessed
  - Required to be administered upon engagement and frequently thereafter

The results of the assessments drive the Care Plan developed with the family

CMARC Services to Children in Foster Care

The actions in the **Care Plan** could include:

- Providing education to meet identified needs; examples include:
    - The impact of toxic stress/ACES using CMARC materials
    - Ways to promote relational health & resilience using CMARC materials
    - The importance of routine well care based on the enhanced schedule for children in foster care
    - Actions to support child development using **Learn the Signs. Act Early** materials

- Linking families to resources to meet identified needs, including:
    - The medical home
    - Services to support the caregiver-child-family using the CMARC Resource Directory
    - Social-Emotional Services, including specialized therapies, using the CMARC Resource Directory

Training for CMARC Staff

All new staff are required to complete training, which includes:

- Videos from the **Center on the Developing Child at Harvard University** on early brain development, toxic stress, the science of neglect & resiliency
- The **Removed Part 1 & 2** videos, which demonstrate the journey through the foster care system through the eyes of the child

In March 2022, all staff were provided a training offered by **Dr. Gerri Mattson**, Pediatric Medical Consultant with the Division of Child and Family Well-Being entitled **Caring for Infants and Children in Foster Care**

Collaboration

CMARC Care Managers at County Level:

- CCNC, Health Plans, DSS caseworkers, medical home and other care team members ensure comprehensive, coordinated care to individual children engaged in CMARC services without duplication of services

- Many have developed strong partnerships with DSS Child Protective Services (CPS) through the Plan of Safe Care Initiative (POSC)

CMARC Program at the State Level:

- Has been an active participant in the Fostering Health NC initiative since its inception
- Participate with the Division of Health Benefits (DHB) with Foster Care initiatives

Resources

Ginger Wilder BSN, RN, CCM

CMARC Program Manager

School, Adolescent, and Child Health Unit

Division of Child and Family Well-being, Whole Health Section

NC Department of Health and Human Services

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Questions?