

MEETING THE HEALTH CARE NEEDS OF CHILDREN IN FOSTER CARE

Hon. Pamela L. Abernethy (Ret.)
Judge in Residence, JCIP
CRB Every Day Counts Conference May 3, 2014

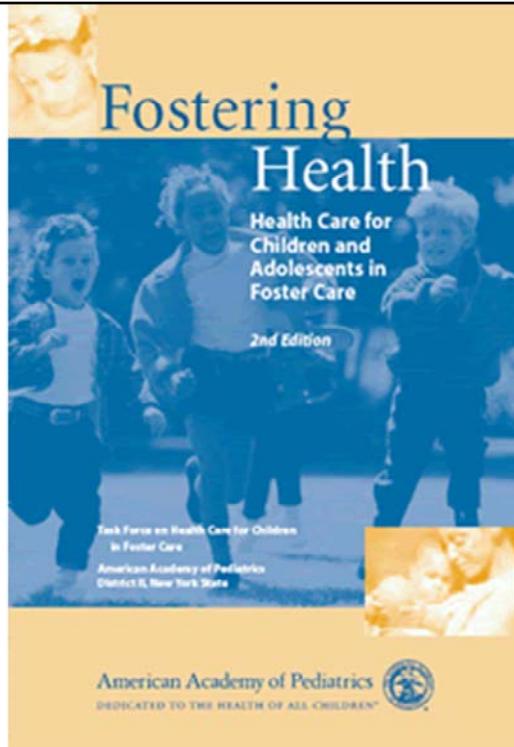
What are *Health Care Needs*?

- PHYSICAL HEALTH
- DENTAL HEALTH
- MENTAL HEALTH



Outcomes

- Understand the characteristics of children in care and why CRB health monitoring is so critical
- Understand what Oregon law, administrative rules and DHS policies require.
- Understand why Oregon's new Coordinated Care Organizations may help improve care for foster children.
- Ask questions on checklist for all CRB reviews and especially for children under 6 and teenagers.
- Be inspired to read suggested resource materials.



Who are the Children?



- In 2008 40% of Oregon children in foster care were under age 3.
- In Utah study
 - 35% were overweight or obese
 - 30% needed specialty care for a physical problem
 - 35% were on psychotropic medications
- Early childhood tooth decay is rampant in the US with children of poverty most affected



MH 18% odd or co; 17% RAD. 15% mood disorders.

Who are the Children?

- 60 percent of children in foster care experience a chronic medical condition,
- One-quarter suffer from three or more chronic health conditions.
- Roughly 35 percent have significant oral health problems.
- Nearly 70 percent of children in foster care exhibit moderate to severe mental health problems,
- 40 percent to 60 percent are diagnosed with at least one psychiatric disorder.
- Houshvar, Shadi, *Addressing the Health Care Needs of Children in the Child Welfare System*
www.firstfocus.net

In a study of health care utilization in Florida, California, and Pennsylvania, Mathematical Policy Research found that the likelihood that foster care children received preventive check-ups ranged from 28 percent in Florida to 41 percent in Pennsylvania.⁵⁶ The authors concluded that overall, many foster care children did not receive routine check-ups, and more over, only a small number received an assessment during the first two months of placement in foster care.

By Shadi Houshyar, PhD

What are their special needs for health care?

- ▶ **General needs include:**
 - Continuity of care
 - Ongoing mental health services
 - Medication management
- ▶ **Focused strategies to address prevalent conditions.**
- ▶ **Special attention to :**
 - Infants and Toddlers
 - Teenagers Aging Out
 - Dental Care
 - Psychotropics



Reference handout “child welfare information gateway”

What are their special needs for information

- To foster family upon placement
 - Especially after disruption or a return to care from parent.
- To the biological family upon reunification
- To a family who is seriously considering adoption of a particular child
- To the family upon adoption
- To the youth upon aging out of the system: SB 123 passed in 2013: Foster Children Bill of Rights
 - http://www.oregon.gov/dhs/children/fostercare/pages/ind_living/resources.aspx ILP website



SB 123 provides that any child over 14 has the right to be provided with written information within 60 days of placement or any change of placement about how to obtain medical dental vision mental health services or other treatment including services and treatments available without parental consent under state law.

The department has updated a number of rules pertaining to Youth Transitions this past year (I-B.2.3.5 413-030-0400 thru 0460) in summary the health care area for Youth transition requires; a plan for youth to have access to their health and immunization records, access to extend health care coverage through Chafee Medical program; and information pertaining to a health care advance directive.

As referenced in the Chafee ILP section of the State report; Chafee Medical was implemented on May 1, 2010. The number of youth accessing the program steadily increased through June 2012. (see appendix: Chafee Medical Program Enrollment by Month)

Oregon Advance Directive Representative/Proxy: The department has continued to inform and educate DHS supervisors and Caseworkers, ILP Providers, youth age 17 & ½ and older in foster care (as well as younger youth in foster care who participate in the ILP Programs), Foster Parents, and Community Supporters throughout the state about the Federal requirement (effective October 2010) to advise youth of their right to select a Health Care Representative. The role of this Health Care Representative would be to speak on the youth's behalf should he/she become incapacitated and not able to do so--the youth shall be informed of their right to select a representative during the Benchmark Review and/or before the youth attains 18 years of age.

Information regarding the Federal mandate is published in the Department's Youth Transitions Policy and the Procedure Manual for DHS Supervisors and Caseworkers. In addition, when the Youth transition (ILP) website was redesigned, http://www.oregon.gov/dhs/children/fostercare/pages/ind_living/resources.aspx material and the specific documents pertaining to this new requirement are posted and include direct links to the letter for youth and the Information Memorandum Transmittal to DHS that was sent out prior. Brochures have been sent out with the letters and DVD's addressing this subject have been

What does Oregon law require?

- Refer to attached CRB Checklist for Health Care
- Required list on left hand side



I am going to quickly review the text of the 2 main statutes, 418.325 and 419B.346. Although a bit dense I have placed the texts on the following slides because I think its important to know what is required by law, not just a statement in policy. We will discuss later the question of how this might impact RE. I suggest you follow along not with the dense slides but with the summary of what's required is on the checklist at the back of your materials. You might refer to that now as we discuss the text on the slides.

What does Oregon law require? ORS 418.325

- ▶ (1) A child-caring agency shall safeguard the health of each ward or other dependent or delinquent child in its care by providing for medical examinations of each child by a qualified physician at the following intervals:
 - ▶ (a) Three examinations during the first year of the child's life;
 - ▶ (b) One examination during the second year of the child's life;
 - ▶ (c) One examination at the age of four;
 - ▶ (d) One examination at the age of six;
 - ▶ (e) One examination at the age of nine; and
 - ▶ (f) One examination at the age of 14.

- ▶ (2) If an examination under subsection (1) of this section has not occurred within six months prior to the transfer for adoption of the custody of a child by a child-caring agency to the prospective adoptive parents of such child, a child-caring agency shall provide for a medical examination of such child within six months prior to such transfer.

ORS 418.325 continued

- ▶ (3) Any testing that occurs at intervals other than those specified in subsections (1) and (2) of this section shall not be considered to be in lieu of the required examinations. However, nothing in subsections (1) and (2) of this section is intended to limit more frequent examinations that are dictated by the general state of the child's health or by any particular condition.
- ▶ (4) Within 90 days of obtaining guardianship over a child under six years of age, a child-caring agency shall provide for such child to be:
 - ▶ (a) Inoculated as determined appropriate by the county public health department; and
 - ▶ (b) Tested for:
 - ▶ (A) Phenylketonuria pursuant to ORS [433.285 \(Policy to control metabolic diseases\)](#);
 - ▶ (B) Visual and aural acuity consistent with the child's age;
 - ▶ (C) Sickle-cell anemia;
 - ▶ (D) Effects of rubella, if any;
 - ▶ (E) Effects of parental venereal disease, if any; and
 - ▶ (F) The hereditary or congenital effects of parental use of drugs or controlled substances.
- ▶ (5) Within six months prior to the transfer for adoption of the custody of a child by a child-caring agency to the prospective adoptive parents of such child, the child-caring agency shall provide for such child to have a complete physical examination by a physician, including but not limited to inspection for evidence of child abuse in accordance with rules of the Department of Human Services, and be tested for visual and aural acuity consistent with the child's age.

ORS 418.325 continued

- ▶ (6) A child-caring agency shall record the results of tests provided a child pursuant to subsections (1) to (5) of this section in the child's health record. The child's health record shall be kept as a part of the agency's total records of that child. The child's health record shall be made available to both natural parents and to both prospective foster or adoptive parents of that child. A qualified member of a child-caring agency under the supervision of a qualified physician shall explain to adoptive parents the medical factors possible as a result of a child's birth history, hereditary or congenital defects, or disease or disability experience

What does Oregon law require?

ORS 419B.346 serious/chronic

- ▶ Whenever a ward who is in need of medical care or other special treatment by reason of physical or mental condition is placed in the custody of the Department of Human Services by the juvenile court, the department shall prepare a plan for care or treatment within 14 days after assuming custody of the ward. The court may indicate in general terms the type of care which it regards as initially appropriate.
 - ▶ A copy of the plan, including a time schedule for its implementation, shall be sent to the juvenile court that committed the ward to the department. *The court may at any time request regular progress reports on implementation of the plan.*
 - ▶ The department shall notify the court when the plan is implemented, and shall report to the court concerning the progress of the ward *annually thereafter*. If the plan is subsequently revised, the department shall notify the court of the revisions and the reasons for the revisions.
- ▶ [1993 c.33 §111; 2003 c.396 §60]

Immunizations ORS 418.325(4)

- Child welfare is required to have all children in its legal custody immunized. A substitute caregiver cannot make the decision not to immunize a child in child welfare's legal custody.
- Immunizations required are listed in DHS policy appendix. [**charts are provided in your materials.**]
- *Chapter IV-Services to Children Appendix 4.11*

ORS 418.517(3)(d)

- Specified follow-up and monitoring by the department of a child taking psychotropic medication including, but not limited to, an annual review of medications by a licensed medical professional, or qualified mental health professional with authority to prescribe drugs, other than the prescriber, if the child has more than two prescriptions for psychotropic medications or if the child is under the age of six years.

In addition, youth in foster care are often prescribed two or three medications, the effects of which are not well-known in combination.⁴⁵ In a 2008 study of Texas children with Medicaid coverage, Zito and colleagues found that youth in foster care received at least three times more psychotropic drugs than other children in poor families. Zito and colleagues report that from September 2003 to August 2004, of 32,135 Texas foster care children enrolled in Medicaid, 12,189 (38 percent) were prescribed one or more psychotropic medications. In addition, 41.3 percent of a random subgroup of 472 youths received three or more psychotropic drugs daily.

ORS 418.517(4) and (5)

- (4) A psychotropic medication may not be prescribed for a child under this section unless it is used for a medically accepted indication that is age appropriate.
- (5) Any parent, legal representative of the parent, legal representative of the child or court appointed special advocate may petition the juvenile court for a hearing [if any] objects to the use of or the prescribed dosage of the psychotropic medication
- The court may order that administration of the medication be discontinued or the prescribed dosage be modified upon a showing that either the prescribed medication or the dosage, or both, are inappropriate

A psychotropic medication may not be prescribed for a child under this section unless it is used for a medically accepted indication that is age appropriate.

(5) Any parent, legal representative of the parent, legal representative of the child or court appointed special advocate may petition the juvenile court for a hearing if the parent, the representative of the parent, if any, the legal representative of the child or the advocate objects to the use of or the prescribed dosage of the psychotropic medication. The court may order an independent evaluation of the need for or the prescribed dosage of the medication

What does DHS **policy** require?

30 day initial medical exam

- The caseworker must ensure that every child in the department's legal custody must be referred for a medical exam within the first 30 days of placement in substitute care.
- Request that the substitute caregiver schedule a medical exam as soon as feasible.
- The Child Welfare Case Plan also should address the level of involvement of the child's parents in a child's medical care.

CANS Screening

- DHS will refer the child for an age appropriate CANS screening between the 14th and 20th day of out of home care.
- CRB should inquire about CANS screening and whether it resulted in recommended services based on identified health care needs, referrals to particular services or further assessments.
- CRB should determine who is following up on such referrals.

- *Chapter IV Services to Children Ver 2 Section 5: page 2*

What does DHS **policy** require?

Regular preventive care

Regular preventive care appropriate to the child's age and condition, including:

1. Immunizations and tuberculin (TB) tests (Refer to Appendix 4.11, Child and Adolescent Immunization Schedule, for guidance on childhood immunizations.);
2. Timely examinations;
3. Timely treatment of non-emergency injuries and illnesses;
4. Ongoing care for serious or chronic conditions; and
5. Emergency treatment whenever necessary

□ Chapter IV- *Services to Children: Ver 3 Section 21*

Caseworker Responsibilities

- Obtain immunization records
- Obtain routine health care
 - Caseworker to collect and maintain child's medical history in the medical section of the case file.
 - Caseworker to review the child's current health conditions, medications, health care providers, and any other special medical or dietary needs (e.g., allergies, diabetes, special formula) during the monthly contact with the substitute caregiver.

Chapter IV- *Services to Children: Ver 3 Section 21*

Caseworker responsibilities: Regular preventive care

- ▶ Ensure the substitute caregiver records all medications on the Foster Home Individual Child Medication Log (CF 1083) or other medication records kept by a licensed child caring agency.
- ▶ Each month review and file a copy of the Foster Home Individual Child Medication Log in the medical section. Questions regarding medications are directed to the personal care RN coordinator in Salem. For more information on psychotropic medications and notifications refer to Psychotropic Medications.
- ▶ Compare the child's current health information with standard height and weight growth charts in Appendix 4.12. Bring significant variations to the standardized norms on the growth charts to the attention of the supervisor.

Chapter IV- Services to Children: Ver 3 Section 21

Caseworker responsibilities cont.

- ▶ Review the child's medical information and services when the case plan is being developed whenever a child is in substitute care (so either the Child Welfare Case Plan CF 333a, or the Family Support Services Case Plan, CF 333e, or a review is being completed). Medical services are incorporated into either of these case plans in Child Description, Their Need and Well Being and on the CF 310 H.
- ▶ Document the child's medical care and services in the CF 310H. Review and update this information as needed, but at least every six months.
- ▶ Copies of medical reports are filed in the Medical Section of the child's case file.

Chapter IV- *Services to Children: Ver 3 Section 21*

0 to 5: Referral to WIC

- **Nutritional resources for a child under 5 years**
- Refer the child's substitute caregiver to the local Oregon Women, Infants and Children • (WIC) clinic. The WIC program provides quality nutrition education for substitute caregivers and services for children up to 5 years

*Chapter IV-Services to Children: Ver 3 Section 21:
Page 18*

TEENAGERS: Referrals to family planning services

- ▶ Explore the need for or interest in family planning information and appropriate referrals with a child 15 years old or older.
- ▶ Provide any child in child welfare custody, who is 15 years of age or older, or any young adult a referral to an appropriate family planning resource when requested.
- ▶ Refer the child to the nearest family planning clinic or the primary care provider.
- ▶ The decisions regarding a pregnancy and related medical care are the statutory right of the child 15 years of age or older.

Chapter IV-Services to Children: Ver 3 Section 21: Page 7

The department has updated a number of rules pertaining to Youth Transitions this past year (I-B.2.3.5 413-030-0400 thru 0460) in summary the health care area for Youth transition requires; a plan for youth to have access to their health and immunization records, access to extend health care coverage through Chafee Medical program; and information pertaining to a health care advance directive.

DHS 2013 Annual Report

Serious or chronic medical needs

- OAR 413-090-0100-0210
- I-E.5.1.2. Personal Care Services
http://www.dhs.state.or.us/policy/childwelfare/manual_1/i-e512.pdf
- *Services to Children: Section 4 Ver 2: Pages 1-5*

- CF 172/172B: PERSONAL CARE SERVICES
REFERRAL, ASSESSMENT and PLAN

Serious or Chronic: WRITTEN PLAN

- When the court identifies a child in need of medical care or other special treatment by reason of physical or mental condition, the caseworker must develop a written plan for the child's care and treatment, and submit the plan to the court within 14 days from the date of custody (ORS 419b.346).

Services to Children: Ver 3 Section 21: Page 2

The 14 day written plan must include:

1. Identifying information including the child's name, date of birth and the identity of the child's parents;
2. A brief summary of child welfare's involvement with the child and a statement of the child's physical or mental health condition;
3. The plan, including treatment goal(s) for the child and time lines to meet those goals; and
4. The planned services for meeting the child's placement and treatment needs.

PROGRESS REPORTS TO COURT AND CRB

- The court/CRB may request regular progress reports once the plan is implemented and the caseworker must report annually to the court about the child's progress. If a plan is revised, the caseworker must prepare a report to the court of the revision of the plan and the reasons for the revision.

Services to Children: Ver 3 Section 21: Page 2

Psychotropic Medications

- ORS 418.517
- OAR 413-070-0400 thru 0490
- I-E.3.3.1. Psychotropic Medication Management
- http://www.dhs.state.or.us/policy/childwelfare/manual_1/i-e331.pdf

• Failure to coordinate and provide continuity of services and the absence of clear guidelines and accountability to ensure that treatment decisions are in a child's best interests create a risk that medication will be prescribed to control a child's behavior. Individual care plans offer the best chance for success.

DHS 2013 plan states: The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications has had significant work in this area over the last year in Oregon.

Oregon is in the second year of a Technical Assistance Grant through Centers for Health Care Strategies for Oversight of Psychotropic Medication for Foster Children. As part of this grant work a Psychotropic Medication Advisory Committee has been formed that meets quarterly. The advisory committee consists of private healthcare providers and mental health providers, foster parents, former foster youth, Medicaid partners and Child Welfare. The advisory committee identified three primary issues to be reviewed; Informed Consent, Communication and Education, and Improving Prescribing Practices. Work groups have been developed to address these issues and work remains underway.

Child Welfare jointly contracts with Oregon Health Authority Children's Mental Health for weekly consultation with a child psychiatrist, and procedures are in place that allows field staff to consult with an on-staff registered nurse for medication related issues.

The Department has expanded its oversight model with annual review of psychotropic medications for children in foster care. Currently, all children on psychotropic medications receive an annual medication review by a registered nurse during the month of their birth date. All children under the age of six receive a review by the consulting psychiatrist. Metabolic monitoring is also addressed during the review process for those children taking antipsychotic medication.

Psychotropic Medications

- “About 50% of children in Medicaid who were prescribed psychotropic medications received no identifiable accompanying behavioral health Rx”
- Recommendations:
 - ▣ Expand access to appropriate and effective behavioral health care
 - ▣ Invest in care coordination
 - ▣ Ensure collaboration across child-serving systems
- *Faces of Medicaid: Examining Children’s Behavioral Health Service Utilization and Expenditures*, www.chcs.org. December 2013.

Center for Health Care Strategies Inc. In Oregon we still need to work on #1. We have wrap around for #2 and with the advent of PCPCH we should have better coordination and oversight of psychotropic med use. For #3.

Resources Psychotropic Medication

Practice and Policy Brief, ABA Center on Children and the Law: Psychotropic Medication and Children in Foster Care

October 2011, JoAnne Solchany, PhD, ARNP.

- www.americanbar.org/content/dam/aba/administrative/child_law/Psych



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Dental care DHS Requirements

- ▶ Ensure each child in substitute care is enrolled in a managed dental plan.
- ▶ Refer each child in DHS's custody for a dental exam within the first 30 days of placement. Dental appointments should begin at the age recommended by the child's pediatrician.
- ▶ Ensure routine tooth cleaning is scheduled with a complete dental exam once every 12 months.
- ▶ Document the name and contact information for the medical professionals providing dental care in the medical section of the child's case record and the CF 310H.
- ▶ When a child is placed in substitute care through a Voluntary Placement Agreement, the child's parents must be consulted prior to obtaining ordinary dental, hygiene or other remedial dental care.
- ▶ *Chapter IV Services to Children: Section 22: Page 1*

Orthodontia

- ▶ Medicaid funds will cover only orthodontia services for Medicaid-eligible children with a dual diagnosis of cleft lip and cleft palate. When the child has the dual diagnosis, the provider must request prior authorization for payment to either DMAP in the case of an "open" card or through the Managed Dental Plan if the child is enrolled.
- ▶ Requests for flexible funds will be considered for orthodontic services needed as part of treatment for a medical condition or because a medical condition developed as a result of dental conditions. The following conditions, with the proper documentation, are a first priority for orthodontic treatment:
 - ▶ Cleft palate
 - ▶ Impacted canines
 - ▶ Impinging overbite
 - ▶ Over jet greater than 9 mm
 - ▶ Syndromes affecting the bone
 - ▶ Syndromes of abnormal craniofacial contour
 - ▶ Malocclusion resulting from traumatic injury

Mental health services: 60 days

- ▶ DHS must refer a child entering substitute care to the local mental health provider for a mental health assessment within 60 days of placement.
- ▶ 2007 data demonstrated that as few as 26% of children over age 3 received a MH assessment within 60 days of placement.
- ▶ DHS must document the results of the mental health assessment and any follow up or treatment services in case notes in the case file's medical section.
- ▶ DHS must share information with the child's substitute caregiver and, when appropriate, with the child's parents.

Mental health services

- ▶ Include the services recommended by the mental health provider as part of the case plan in the Child Safety and Well-Being, Child Description, Their Needs and Well-Being section of the case plan. If all recommended services are not available in the community, consult with the mental health provider to prioritize services. Recommendations and services are documented in case notes.
- ▶ Request a level of need determination and an assessment that includes a Child and Adolescent Services Intensity Instrument (CASII) if a child has particularly complex mental health issues or the child's needs are not addressed in routine mental health care. The child's score on this instrument, combined with other assessment information and relevant risk factors, will determine the level of mental health services a child needs. The CASII is considered a part of the process of level of need determination. The level of need determination process will include recommendations for treatment and/or further evaluation

- The local Mental Health Assessment racking reports are compiled at the state level for monitoring and during the last quarter 2012;
 - Oct-Jan 2013 the timely referral rate was 68%,
 - Oct 2012-Jan 2013 assessed within 60 days was 46%

- As compared to the same time period of 2011;
 - Oct 2012-Jan 2012 the timely referral rate was 81%,
 - Oct 2011-Jan 2012 assessed within 60 days was 56%
- The decrease during this quarter coincides with the new implementation of the CCO model in Oregon.
- Source: DHS Title IV-B Annual Progress and Services Report FY 2013

OAR 413-030-0013: Special Evaluations

1. Caseworker may secure expert evaluation to determine Rx needs or assist in assessing child safety when there is a specific condition or behavior that requires additional professional information. Examples include, not limited to:
 - (a) Child displaying unusual or bizarre behaviors that are indication of emotional or behavioral problems;
 - (b) Physical illness, physical disability or mental illness
 - (c) Suicidal or (d) Homicidal ideation.

How to Do Better by Babies



0 to 3: Referral to Early Intervention

- ▶ Children under age 3 placed in substitute care must be referred to Early Intervention (EI) for a developmental screening within 30 days of being placed in substitute care. The Caseworker is to use the CPS Early Intervention Form. *Services to Children Chapter 2 Assessment: Section 11: Page 1*
- ▶ An “IFSP” is the Individualized Family Service Plan developed through Part C to address Early Intervention priorities, desired outcomes, and services.
- ▶ If recommended by EI, EI will refer the child to an infant mental health specialist for a comprehensive mental health assessment.

Infants and Toddlers

- ▶ Traumatized children with attachment or emotional regulation issues.
- ▶ Types of Rx/services: dyadic therapy with child/foster parent, therapeutic foster care, relationship based visitation, work with Early Head Start or Head Start teachers, Relief Nursery therapeutic classroom/home visiting (some counties)
- ▶ “Early Childhood Service Intensity Instrument” ESCI



Infants and Toddlers: Resources

- **QUESTIONS EVERY JUDGE AND LAWYER SHOULD ASK ABOUT INFANTS : PROVIDED**

- [www.npr.org/programs/atc/features/2003/mar/juvenile_court/...](http://www.npr.org/programs/atc/features/2003/mar/juvenile_court/) · PDF file

- Abernethy, P. & Hall, M.A. (2009). Improving Outcomes for Infants and Toddlers in the Child Welfare System. *Zero to Three, 29 (6), 28-33.*

Infants and Toddlers: Resources

- [Infant/Toddler Development, Screening, and Assessment ...](#)
- www.zerotothree.org/public-policy/state-community-policy/nitcci/... · PDF file
- **Infant/Toddler**. Development, Screening, and Assessment. National **Infant & Toddler** Child Care Initiative. U.S. Department of . Health and Human Services

Zero to Three: Resource

- **Supporting the Development of Infants and Toddlers in the Child Welfare System**
- www.zerotothree.org/public-policy/webinars-conference-calls/
- This is a Webinar

Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351)

- Medicaid and child welfare agencies must create together a health oversight and coordination plan,
- in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services,
- for the ongoing oversight and coordination of health care services for any child in a foster care placement.

Health Oversight and Coordination Plans *HOCP*

- ▶ The plan must ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs.



Oregon's Approach: The Coordinated Care Organization

- Oregon does not have a HOCP *per se* but has developed new Coordinated Care Organizations to provide “better health and better care at lower costs” for our OHP population. The “Triple Aim.”
- CCO's are designed to have one medical home for a child.
- CCO's are designed to use electronic medical records.
- CCO's are designed to coordinate all aspects of health care.

Coordinated care organization means an organization meeting criteria adopted by the Oregon Health Authority under ORS [414.625 \(Coordinated care organizations\)](#)

Coordinated Care Organizations

- There are 16 CCOs in every part of Oregon serving ~95% of OHP
- Governed by a partnership between health care providers, members, those taking financial risk.
- Community Advisory Councils
- Mental, physical, dental care held to one budget.
- Responsible for health outcomes
- Receive incentives for quality
- Budgets grow at 3.4% per capita per year

2013-2015 CCO budget is 2 percentage points per capita below national growth trends.

Slide courtesy of the Oregon Health Authority

11

Incentive Metrics Examples

- Adolescent Well Child Visits
- Screening Brief Intervention Referral Intervention and Treatment (SBIRT) Screening
- Depression Screening
- **Developmental Screening (0-36 months)**
- Follow Up Care for Children Prescribed ADHD Medication
- **Mental and Physical Health Assessments for Children in DHS Custody**
- **Patient Centered Primary Care Home Enrollment (PCPCH)**
- Timeliness of Prenatal Care

- **Slide Courtesy of the Oregon Health Authority**

48

2 Child Welfare staff are actively involved in Oregon's Children Health Policy Team to ensure children needs are not forgotten in the Health System Transformation. DHS Title IV-B Annual Progress and Services Report FY 2013 (5. Health Care Services).

CCO's Early Work...

- Reducing unnecessary ER visits.
- Working to better integrate mental and physical health care.
- Developing a complex care model for patients with chronic and complex conditions.
- Hiring community outreach workers to help people manage the most acute and chronic conditions.
- Setting aside dollars from its global budget to help the county public health department hire a community epidemiologist and two community health analysts who will develop evidence- based tobacco prevention measures.
- **Developing processes that enable families to address all of their child's health needs at a single clinic.**

⁴⁹
– **Slide Courtesy of the Oregon Health Authority**

The Patient Centered Primary Care Home (PCPCH): Oregon's Medical Home Model

- The medical home is an innovative health care model utilized by pediatricians to provide accessible, continuous, comprehensive, patient and family-centered, coordinated, compassionate, and culturally effective care to children. The medical home is important for all children, but critically so for children in foster care, many of whom have health challenges.

A medical home would ensure that children receive care that is family centered, comprehensive, coordinated and continuous over time. A medical home would provide continuity and ensure that children can retain a single care provider, even in times of transition. Under this model, children and youth in foster care would receive all of their health care services from a single health care professional.

ORS 414.025(13)

- ▶ *Patient centered primary care home means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS [414.655 \(Patient centered primary care homes in coordinated care organizations\)](#) and that incorporates the following core attributes:*
 - ▶ (a) Access to care;
 - ▶ (b) Accountability to consumers and to the community;
 - ▶ (c) Comprehensive whole person care;
 - ▶ (d) Continuity of care;
 - ▶ (e) Coordination and integration of care; and
 - ▶ (f) Person and family centered care

Central Staff Enhancements

- 2 new positions “Medical Assistance Resource Coordinators” are centralized staff that help caseworkers and foster parents navigate through the new CCO model to ensure access to health care services.
- 2012-3: DHS developed routine consultation model regarding children that may involve weekly consults with Child psychiatrist, Registered Nurse, Physicians, Pharmacist etc. to determine Rx.
 - Limited DHS medical staff/contracts with Oregon Health Authority to expand consultation for children.

CCO Coos Bay: FEARsome Clinic

- In Coos Bay foster families can come to the FEARsome clinic in the Waterfall Community Center.
- At FEARsome, children can receive screenings from a dentist, a mental health therapist, and a pediatrician all under one roof. Children under age three also receive a developmental screening.
- Foster parents get training on how to access the children's portable medical summary so they can maintain the medical log required of them by the Oregon Department of Human Services.

One example of how this is working in Oregon is one CCO came together to provide better health for the people they serve. Foster families in the Coos Bay area can come to the FEARsome clinic, which is housed within the Waterfall Community Health Center. At FEARsome, children can receive screenings from a dentist, a mental health therapist, and a pediatrician all under one roof. Children under age three also receive a developmental screening. Foster parents get training on how to access the children's portable medical summary so they can maintain the medical log required of them by the Oregon Department of Human Services. Their next steps are to add a school representative so there is coordination and collaboration for children.

FEARsome continued

- Next steps are to add a school representative so there is coordination and collaboration for children.
- CRB Field manager **Laurie Judd** agrees that the clinic promotes better care/better outcomes:
- “The FEARsome Clinic has helped DHS meet federal requirements for timely assessments and can actually help get children with serious dental or medical needs into treatment more quickly.”



Discussion

- How can the CRB ensure that the health care needs of all foster children are being met?



Health related Case law

- The primary concern in changing the permanency plan from reunification with the parent is always the child's health and safety. ORS 419B.476(2)(a); see State ex rel. Dept. of Human Services v. Shugars, 208 Or.App. 694, 712, 145 P.3d 354 (2006)(Shugars II).
- Dept. of Human Services v. S.M., 256 Or.App. 15, 24-29, 300 P.3d 1254, rev. allowed, 353 Or. 867 (2013)(Court may order immunization of children over parents' objection pursuant to medical advice) (Provides summary of nonparent's authority to make health-care decisions under ORS 419B)

HANDOUTS

- CRB CHECKLIST FOR HEALTHCARE (NEW)
- IMMUNIZATION CHART
- QUESTIONS EVERY JUDGE AND LAWYER SHOULD ASK ABOUT INFANTS AND TODDLERS
- CHILDREN'S DENTAL HEALTH: THE NEXT FRONTIER IN WELL-BEING
- ABA PRACTICE AND POLICY BRIEF PSYCHOTROPIC MEDICATION AND CHILDREN IN FOSTER CARE: TIPS FOR ADVOCATES AND JUDGES
- DHS Title IV-B Annual Progress and Services Report FY 2013 "Health Care Services"

MORE RESOURCES

(Click the title to access the resource)

- [*FOSTERING HEALTH: Health Care for Children and Adolescents in Foster Care*](#)
- [*Healthy Foster Care America – A program of the American Academy of Pediatrics*](#)
- [*State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children’s Care*](#)
- [*Moving to Adulthood: A Handout for Youth Aging Out of Foster Care*](#)