CARE COORDINATION FOR FOSTER CHILDREN

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Providing dedicated support for children entering foster care and to assist in addressing gaps in services and supports, in order to improve utilization of healthcare resources in this high-risk patient population.
ROLE OF THE CARE COORDINATOR

The care coordinator works with the physician and the foster family to develop a comprehensive plan of care. The care coordinator will ensure that all children receive on-going preventative care. In addition to the child’s health maintenance visits, the care coordinator is available by appointment or by phone to help connect foster parents with any services they may need as they care for the child. Regular communication and collaboration will occur between the care coordinator and the child’s caseworker and outside providers to ensure coordinated support for the physical and emotional needs of children in foster care.
IDENTIFICATION

- Guarantor
- Problem List
- Scrubs
- Identification at well child visit
- Families or Caseworkers calling to schedule an appointment
  - Call Clinic
  - Call Care Coordinator directly
- Assigned by insurance plans
COMPONENTS OF CARE COORDINATION

Foster Child is Identified

Care Coordination

Initial / Intake
INITIAL CARE COORDINATION

- Contacts Caseworker for background information (e.g. medical, social, etc)
- Contacts foster parent
- Acquire needed ROI’s
- Requests and tracks medical records including past primary care, ED, specialist, MH if receiving MH services both currently or in the past
- Medical records are given in a packet to provider
- Care Coordinators schedules child for initial appointment
COMPONENTS OF CARE COORDINATION

- Foster Child is Identified
  - Care Coordination
    - Initial / Intake
    - On-Going
      - Support to Children & Families
      - Tracking
SUPPORT TO CHILD AND FAMILY

- Continued communication with Case Worker
- Promote information sharing between PCP and all community partners working with the child
- Follow up on referrals
- Coordinator any f/u plans by providers (weight checks, asthma f/u, lab work, etc)
- Make sure children are up to date on well child, ASQ, PHQ, immunizations, etc
- Contact families after ED visits
  - Schedule f/u appts
  - Provide education on accessing triage services prior to ED if appropriate
SUPPORT TO CHILD AND FAMILY CONT.

- Assist with insurance/authorizations if appropriate
- Help foster parents with community resources for the children in their home
- Available to foster parents to help with navigating through the medical system
- Track children in placement changes so to ensure new foster family is aware of child’s needs and services
- Available to biological and adoptive families during transition
- Trauma-Informed Workshop for foster parents
TRACKING

- WCC
- Referrals
- ED visits
- Developmental screenings (ASQ)
- Immunizations
- Depression screenings (PHQ’s)
- CRAFT screenings
COMPONENTS OF CARE COORDINATION

Foster Child is Identified

Care Coordination

Initial / Intake

On-Going

Support to Children & Families

Tracking
<table>
<thead>
<tr>
<th>Data 2009 - 2014</th>
<th>Foster Children in Medical Home Program (190)</th>
<th>Foster Children not in Medical Home Program (191)</th>
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<tbody>
<tr>
<td>% of Well-Child Visits Completed</td>
<td>76%</td>
<td>58%</td>
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<tr>
<td>% Vaccines Current</td>
<td>73%</td>
<td>67%</td>
</tr>
<tr>
<td>% Developmental Screenings Completed</td>
<td>57%</td>
<td>31%</td>
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<tr>
<td>% Referrals Completed</td>
<td>68%</td>
<td>45%</td>
</tr>
<tr>
<td>Total # ED Visits</td>
<td>112</td>
<td>251</td>
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<tr>
<td>Avg # of ED Visits per Child</td>
<td>0.59</td>
<td>2.39</td>
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<tr>
<td>Total # Hospital Admissions</td>
<td>7</td>
<td>53</td>
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<tr>
<td>Avg # of Hospital Admissions per Child</td>
<td>0.036</td>
<td>0.505</td>
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Purpose of Study: To collect information about the value of enhanced care coordination for foster children in a primary care pediatric practice.

Used a modified version of Dr. Richard Antonelli’s Care Coordination Measurement Tool.

For a period of 8 months, documented care coordination tasks related to foster children in Excel spreadsheet, capturing patient demographic information, the type of work performed, and the outcomes prevented or occurred.

During the 8 month period, 71 children met the population criteria and had at least one social work care coordination encounter.
<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Study #</th>
<th>Patient Age</th>
<th>Patient Level</th>
<th>PCP</th>
<th>Focus</th>
<th>Care Coordination Needs</th>
<th>Activity Codes</th>
<th>Outcomes Prevented</th>
<th>Occurred</th>
<th>Time Spent</th>
<th>Notes/Comments</th>
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### Patient Level

1. CSHCN, + medical condition; + behavioral/mental health condition
2. CSHCN, + medical condition; no behavioral/mental health condition
3. CSHCN, - medical condition; + behavioral/mental health condition
4. CSHCN, - medical condition; no behavioral/mental health condition

Medical conditions are diagnostic conditions followed by PCP or subspecialists, to include developmental delays, h/o prematurity, h/o NAS, FTT, etc.

Behavioral/Mental health conditions are diagnostic conditions, with or without psychotropic prescription, followed by PCP, child psychologist, licensed therapist, and/or child psychiatrist

### Focus of Encounter

(Choose ONE)

1. Developmental Health Maintenance
2. Mental Health/Behavioral Health Maintenance
3. Clinical/Medical Management
4. Immunizations
5. Growth/Nutrition
6. Education/School
7. Referral Management
8. Social Services
9. Legal/Court

### Care Coordination Needs

(Choose all that apply)

1. Facilitation of communication between systems (DHS, PCP, foster parents, mental health biopsychosocial, school, other programs)
2. Make appointments
3. Obtain releases and outside medical records
4. Coordination with outside mental health agencies
5. Coordinate referrals (scheduling, insurance, identification of community resource)
6. Coordinate with pharmacy, medical supplies
7. Advise/manage patient/family expectations
8. Facilitate transportation
9. Arrange or attend multidisciplinary care conference
10. Coordinate abuse/neglect assessment

### Activity Necessary to Fulfill Needs

(Choose ONE)

- Telephone
- Letter
- Meeting
- Email
- Fax
- Page

### Outcomes

As a result of this care coordination, the following was PREVENTED

(choose all that apply)

1a. ED visit
1b. PCP visit
1c. Subspecialist visit
1d. Hospitalization
1e. Specialized therapies (Speech, PT, OT, etc.) visit
1f. Disruption of foster care placement
1g. Hospitalization
1h. I don't know
1i. Break in medical and/or mental health care/treatment

As a result of this care coordination, the following OCCURRED

(choose all that apply)

2a. Advised, educated family on home care plan
2b. Referral to ED
2c. Referral to PCP for urgent care
2d. Referral for medical or mental health hospitalization
2e. EMR updated with accurate information
2f. Referral for specialized therapies (PT, OT, Speech, etc.)
2g. Coordination of follow up with a subspecialist
2h. Elimination of barrier to care
2i. Medical team review of outside records
2j. Referral to outside mental health treatment
2k. Preparation/education of DHS
2l. Advocacy for patient
2m. Met immediate needs of patient/family
2n. Outcome pending
2o. I don't know
As a result of this care coordination, the following outcomes occurred...
MODELS FOR FOSTER CARE COORDINATION

- Randall Children’s Clinic—1 full time social worker and 1 full time RN managing approximately 200 foster children.
- Doernbecher-1 half time foster care social worker coordinating care for approximately 70 kids.
- Kaiser- Incorporating foster care coordination as part of a larger initiative to enhance care coordination for children with complex medical/social/mental health needs--“Team Based Care.”
CASE STUDY

- 3 siblings placed into foster care due to: exposure to domestic violence, father’s involvement in criminal activities and mother’s inability to follow a safety plan and keep the children safe from these high risk situations
- Referred by foster parent
- Medical care was limited, had used multiple clinics throughout Portland, including our clinic
- Scheduled for health exam and Intake assessment process
  - Health issues
  - Developmental issues
  - Mental Health issues
- Services:
  - Preventative Care
  - Individual and Family therapy
  - Developmental Evaluation
  - Speech Therapy
  - Referrals to Specialist
  - Care Coordination
- All of the children were moved 4 times between 5 different foster homes during the 3 years they were in care
  - Foster parents were unable to handle challenging behaviors
  - Foster parents were unable to have more than one child in their home
  - 2 of the children had an unsuccessful return home early in their placement in foster care
Outcomes

- All services followed the children during their time in foster care and during their transition home.

- At this point the children remain in their mother’s care. All of the children are reestablishing relationships with their mother.
  - Mom is providing a home that is safe and supportive to her children.
  - She is taking care of all of the needs of her children including their medical and psychological needs.
  - Mom continued to take the children to therapy to assist in this continued transition period.
  - Foster care medical home helped mom define and develop her own support network and she has utilized her supports to assist her in raising her children.

We were the only, or one of the only constants in these children’s lives during their 3 years in foster care. Having a consistent medical home care coordinator ensured that these children were not lost to any services which not only helped them address important medical issues but also provided the continuity and behavioral health support needed to successfully reunite with their mother.
THANK YOU