What is Fostering Health NC? There are approximately 9,000 children in foster care in North Carolina. These children have special health care needs. Often because of the circumstances that led them to be placed into foster care, their physical, developmental, mental/social-emotional and oral health care has been inconsistent and sometimes impacted by crisis or injury. Fostering Health NC, a project of the North Carolina Pediatric Society, is focused on building and strengthening medical homes for infants, children, adolescents and young adults in foster care through integrated communications and coordination of care through a unique partnership among local Departments of Social Services, CCNC Networks, the pediatric care team, the child and the child’s family.

A. Identifying Patients in Foster Care & Obtaining Medical Records
Children entering foster care are in the custody of the local Department of Social Services (DSS). DSS is responsible for collecting and providing medical and other history about these children and young adults. The vast majority of children in foster care are categorically eligible for Medicaid. Your CCNC network staff and care managers (CCNC network care managers and local health department CC4C care managers) have access to Medicaid claims data through the Informatics Center and to information about individual patients through the Provider Portal and Case Management Information System (CMIS). Your care managers can help you identify existing children in foster care already in your practice and access supplemental patient history information.

B. Frequency of Visits
Children in foster care need to be seen early and more often to monitor, support, educate and empower children and youth and their foster and biological parents. The American Academy of Pediatrics (AAP) and Child Welfare League of America (CWLA) have published standards for health care for children and youth in foster care which specify the parameters for high-quality health care. These standards are available in the AAP Standards of Care handout found in the Fostering Health NC Online Library and from the AAP website. [See http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx].

Summary of the AAP Standards: Children & Young Adults Should Be Seen Early and Often Upon Entry into Foster Care
- 0-6 months of age: Should be seen every month
- 6-24 months of age: Should be seen every 3 months
- 2-21 years and times of significant change (e.g., change in placement, reunification): Should be seen every 6 months

According to the current NC Health Check Billing Guide, there is no limit on the number of well-child visits since these enhanced visits are medically necessary.

C. Types of Visits
According to the AAP Standards of Care, the Initial Visit should occur within 72 hours of placement into foster care (NC Division of Social Services standard for completing this visit is within seven days). The Initial Visit should be an assessment of acute care needs and an opportunity to get additional information for the comprehensive visit. Note: In most cases, NC health care providers may share protected health information with other providers about a child in DSS custody without written permission. [See the UNC School of Government’s guidance on Sharing Health Information for Treatment for details and legal citations, available in the Fostering Health NC Online Library.]

A second visit, called the 30-day Comprehensive Visit, should occur within 30 days of placement into foster care, unless medically necessary to see the child sooner.

Follow-up Well-Visits should start within 60 to 90 days of placement. Additional health evaluations (mental health, developmental, educational, and dental) should occur based on the child’s age. Refer to the AAP Standards of Care for complete details about the frequency and content.

D. Relevant Codes for These Visits
For the Initial Visit, outpatient E/M office visit codes for a new patient visit (99201-99205) or established patient visit (99211-99215) are recommended. Codes should be used that are appropriate for the complexity of care, level of decision making and amount of face to face time required for the services provided. Often this may be detailed enough to be a 99205 (new patient) or 99215 (established patient). The Initial Visit is intended to be brief. However, prolonged service codes (99354-99355) can be used as appropriate. As an alternative, you can use preventive medicine visit codes for new patients (99381-99385) or established patients (99391-99395), depending on the age of the child in foster care. However, remember that during the Initial Visit you may not be able to complete all Health Check components (i.e., formal developmental screening), therefore it may be best to use an office visit code.
D. Relevant Codes (continued)
For the 30-day Comprehensive Visit, consider using the initial consult codes (99241-99245) because a report with detailed information is being sent back to DSS with recommendations about coordination of care. This level of visit will often meet the criteria for a 99244 or 99245 because of the time, amount of information collected and level of decision making.

The ongoing additional Follow-up Well Visits based on the enhanced AAP schedule are considered periodic or interperiodic visits for children in foster care if the visit is a well-child visit. In those instances, use the established patient preventive medicine visit codes based on the appropriate age of the patient (99391-99395). However, since many of these patients are being seen for follow-up for physical, developmental or mental health conditions (or a combination of these), the established patient office visit codes (99211-99215) are most appropriate and are likely to include the level of complexity consistent with 99214 or 99215. Consider using prolonged service codes (99354, 99355) with the office visit code if there is contact beyond the usual service time for that visit code. [See the AAP Helping Foster and Adoptive Families Cope with Trauma Coding Tips for more detailed information: http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Documents/CodingTips.pdf]

A NOTE ABOUT ICD-9, including V CODES:
Many children in foster care have multiple diagnoses and you should code for all conditions addressed to support the level of complexity for a given visit. Please note that in order for the visit to be counted as a well periodic or interperiodic visit for NC Medicaid, you must include V20.2 or V70.3 in the list of diagnosis codes. Additionally, children in foster care should be identified using the ICD 9 (V60.81) or ICD 10 (Z62.21) code at all visits as one of the diagnosis codes. Additional V codes that may be used for children in foster care can be found within the AAP Coding Tips sheet: http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Documents/CodingTips.pdf

Please also review the Healthy Foster Care America Foster Care Coding Fact Sheet (http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Coding_Facts.pdf) and the CCNC Chronic Condition Report (Fostering Health NC Online Library) for a list of codes commonly used with children in foster care.

E. Sharing Info Among Care Team Members
In order to maximize the utility of health information, care team members (medical home provider, social services case worker, and CC4C or CCNC care manager) should leverage available tools, including the CCNC Provider Portal, to preserve and exchange this information.

Consider encouraging your local DSS office to adopt the recently drafted Health Summary Forms (posted on our online library: http://www.ncped.org/foster-care-medical-home) in place of DSS Forms 5243 and 5244. To ensure that the forms are available to all care team members, you should send completed copies to your DSS contact and your CCNC/CC4C care manager so he/she can upload them to Provider Portal.

Important: While CCNC Provider Portal offers robust claims-based information, it has a notable limitation. Drugs used to treat substance abuse will not appear on medication lists in Provider Portal. Such drugs include: Naltrexone – Revia, Vivotril; Disulfiram – Antabuse; Acamprosate – Campral; Buprenorphine – Subutex; Buprenex; Buprenorphine/naloxone – Suboxone, Zubsolv.

F. Screening for Mental and Social-Emotional Health Concerns

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.

- The PEDS or ASQ-3 is required at 6, 12, 18 or 24 months, and 3, 4, and 5 years of age and should be reported as 96110 EP. These tools screen for social-emotional concerns as part of a general developmental screening but are not diagnostic tools and a child in foster care benefits from additional, more specific social-emotional screening.
- The MCHAT is required at the 18 and 24 month visits and is billed as 99420 EP. This is a screen for risk of Autism Spectrum Disorder.

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F. Screening (continued)

Secondary screening tools specific for social-emotional development and mental health concerns include the ASQ-SE, Childhood Depression Inventory, Beck Depression Inventory, PHQ-9 Modified for Teens, Center for Epidemiological Studies Depression Scale, and SCARED. The Pediatric Symptom Checklist (PSC) can be used as a screening tool for primary general health risks and strengths in school age children. The PSC or Youth Pediatric Symptom Checklist (PSC-Y) can be used in adolescents as a secondary screen for learning, social-emotional or mental health concerns. These secondary screening tools should be used in addition to the PEDS, ASQ-3, or PSC (if already used as a primary screen) with children in foster care. Additional screening tools for children and adolescents can be found in the Healthy Child and Adolescent Development Promotion and Screening for Risk handout found in the Fostering Health NC Online Library. Screening with any of these secondary screening tools can be billed using 99420 EP for Medicaid or 99420 TJ for Health Choice. Medicaid and Health Choice allow the use of two units of 99420 per visit.

Symptoms and Behaviors That May Be Observed in Children in Foster Care

These may indicate that a child is not coping well and having problems related to social-emotional development and mental health.

- Sleep problems
- Feeding and Eating issues
- Toileting issues (i.e., constipation, encopresis, enuresis, regression of toileting skills)
- Self-regulation issues (inability to console or soothe or calm self, impulsive actions)
- Frequent severe temper tantrums
- Self-abuse (such as biting or hitting self)
- Aggressive with other children
- Defiance/arguing
- Frequently in trouble at school and with peers for fighting and disrupting
- Hypervigilance, anxiety, or exaggerated response
- Excessive crying or worrying
- Flat affect, withdrawn, not smiling, resists cuddling in infants (problems with attachment)
- Dissociation (detachment, numbing, compliance, fantasy)
- Difficulty acquiring developmental milestones in infants
- Difficulty with school skill acquisition and keeping up in school
- Trouble keeping school work and home life organized
- Losing details can lead to confabulation, viewed by others as lying
- Inappropriate sexual behaviors or gestures

See the Resource Section at the end for more information, especially the AAP’s Helping Foster and Adoptive Families Cope with Trauma: A Guide for Pediatricians.
G. Mental/Social-Emotional Health Evaluation and Resources

All children in foster care should have a validated social-emotional screening. Children who have a positive screening or a known mental health condition should have a comprehensive mental health evaluation by a mental health professional in the practice or by referral to a provider in the community. For infants with a positive screen, there is a critical need to perform a comprehensive evaluation for social-emotional concerns and other developmental concerns with the mother/infant dyad and not just the infant.

There are several resources to evaluate and address social-emotional development in infants and young children and use of these resources is increasing across North Carolina. Again, it is important to assess the mother/infant dyad and not just the infant. CC4C care managers are a great resource to help you identify local resources for children under five years of age. [See https://www.communitycarenc.org/emerging-initiatives/care-coordination-children-cc4c/]

Evidence-based supports and treatments include: Child Parent Psychotherapy, Attachment Biobehavioral Catch Up, and Circle of Security. Older children may benefit from Trauma-Focused Cognitive Behavioral Therapy. A complete list of evidence-based treatments and referrals and community supports for the mother/infant dyad in your community can be found in the Fostering Health NC Online Library. Additionally, the NC Child Treatment Program provides a list of providers trained in these interventions. [See http://www.ncchildtreatmentprogram.org/]

H. Oral Health

Almost 35% of children and adolescents enter foster care with oral health issues. It is important to link these children with dental homes to have a comprehensive oral health evaluation within 30 days of placement into foster care to address their acute and preventive dental and oral health needs. Fluoride varnishing can be performed by your staff for children under three and a half years during a visit. [See the CCNC Pediatric Oral Health Guidance: http://dev.ncfahp.org/Data/Sites/1/ccnc-oral-health.docx]

I. Interacting with Biological Parents/Families

Since the goal is often to reunite children with their biological parents, providers should make every effort to uphold the dignity of biological parents. Providers can do this by carefully safeguarding information they receive about a child’s case and involving biological parents to the maximum extent possible in decisions about care. During visits, especially visits involving both biological and foster parents, providers should ask the child how he/she refers to each parent figure and use that term. Providers should use the term “child in foster care,” not “foster child.” Finally, because the health and well-being of a parent is highly correlated with the child’s, providers should offer support for and facilitate a parent’s emotional health and well-being, providing referrals if needed.

J. Transitions

Children in foster care experience many kinds of transitions and often all at once. Examples include living in a new home with their foster parents, joining a new foster family, visiting biological parents, starting at a new school or child care, making new friends, and sometimes having a new medical home. Children in foster care need time to adjust. Having a clear routine and structure can be very helpful to children at this time. Transitional objects (e.g., a favorite blanket, stuffed animal or other personal item) can help make transitions easier.

The Indiana University’s School of Medicine has published a handout including tips for parents. [See http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/IU-Transitions.pdf]

Adolescents often need to improve their self-management skills in order to plan and prepare for transition from pediatric to adult health care. You can help assess their transition readiness with a variety of tools.


There are a wide variety of tools for both pediatric and adult health care providers on how to address and promote health care transition, which also align with the 2010 AAP/AFAP/ACP policy. [See http://www.gottransition.org/] Information includes the development of portable medical summaries and emergency plans to help with planning for emergencies.
K. Additional Resources

**Foster Care**
AAP Healthy Foster Care America: [www.aap.org/fostercare](http://www.aap.org/fostercare)

**Mental Health**
AAP Mental Health Initiatives: [www.aap.org/mentalhealth](http://www.aap.org/mentalhealth)

*Guide to Psychopharmacology for Pediatricians.* Center for Mental Health Services in Pediatric Primary Care: http://web.jhu.edu/pedmentalhealth/Psychopharmacology%20use.html

**Trauma**

National Child Traumatic Stress Network: [www.nctsn.org](http://www.nctsn.org)

Child Trauma Academy: [www.childtrauma.org](http://www.childtrauma.org)


**Early Brain Development**

Center on the Developing Child at Harvard University: [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)