Delaware's children in foster care – health service utilization

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Introduction & Purpose

June 2014 - DE General Assembly established a Task Force on the Health of Children in Foster care

Task Force charge:

1. Learn more about the health-related needs of children in FC
2. Develop recommendations to improve care

April 2015 Report to the Task Force (and Executive Summary) available at http://www.ccrs.udel.edu/node/489
Background & Importance

• **Foster Care System Delaware**
  – Division of Family Services (DFS), Department of Services for Children, Youth & Their Families (DSCYF)
  – Division of Medicaid & Medical Assistance (DMMA)

• **Health of Children in FC**
  – “a uniquely disadvantaged group” (AAP, 2005)
  – Higher rates of physical, developmental, dental and behavioral health problems compared with other children

Background & Importance

• AAP Policy Statement (2015) prioritizes high-quality pediatric health services, health care coordination, and advocacy for children in foster care

  – Primary responsibility for child welfare services rests with the States
  – Required States to ensure coordination of health-care services, including mental health and dental services, for children in foster care
Approach/Methods

- **Data Sources:**
  - Division of Medicaid & Medical Assistance (DMMA) claims
  - Department of Services for Children, Youth & their Families (DSCYF) foster care placements

- **Time period:** FY 2013 – FY 2014

- **Approach**
  - Analyzed patterns of utilization by age, number of placements, etc.
  - Compared children in foster care (n=1,458) with cohort of all other children participating in Medicaid (n=124,667)
  - Examined special issues highlighted in the literature and identified by task force members
Characteristics of Children in Foster Care (FY 2013 – FY 2014)

- Median age 8.5 years old
- Average 2.3 years in care
- 45-50% White; 50-55% African American
- 60% in New Castle County
- Even gender split
- 71% of children in foster care have one episode of care
- 4-5 placements per episode
Interaction of foster care and other services

- Data here is limited to services billed to Medicaid
- PBHS is not included (16% of placements)
- YRS is not included (13% of placements)
Special Health Needs, Utilization & Costs of Children in Foster Care
FY 2013 – FY 2014
• 91% of children in FC received some kind of medical service in FY 13/14
• 138 children (9%) had no medical claims during this period
Service Utilization of Children in FC compared with other Children in Medicaid
## Selected Diagnoses of Children in Foster Care compared with other Children in Medicaid

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Children in foster care</th>
<th>Other Medicaid eligible children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>10.0%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Autism</td>
<td>1.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Births</td>
<td>0.7%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Central Nervous System Disorder</td>
<td>1.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>1.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome</td>
<td>&lt; 1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>&lt; 1%</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>&lt; 1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>HIV</td>
<td>&lt; 1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>61.0%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Muscular Dystrophy</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Obesity</td>
<td>2.7%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>2.0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Spina Bifada</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Average Billed* Amount of Services Provided to Children in FC compared with other Children in Medicaid

*Paid amount not available. Billed amount is typically more than the paid amount and gives a measure of consumption. Billed amount is not a measure of cost.
Behavioral Health

- Attention Deficit Hyperactivity Disorder (ADHD) is the most frequent behavioral claim (14%).

- The top 5 diagnoses for behavioral claims encompass almost half of all behavioral claims (46%).
Average Cost of Prescription Drugs for Children in FC compared with other Children in Medicaid

Average Per-child Cost Comparison,
Children in Foster Care & Other Medicaid Eligible Children, Prescriptions

- Mean Cost of Psychotropic Prescriptions:
  - Children in Foster Care: $1,602
  - Other Medicaid eligible children: $244

- Mean Cost of Non-Psychotropic Prescriptions:
  - Children in Foster Care: $717
  - Other Medicaid eligible children: $508

- TOTAL average cost per child:
  - Children in Foster Care: $2,319
  - Other Medicaid eligible children: $752
Average Cost of Psychotropic Prescription Drugs by Age of Children in Foster Care

Mean Cost of Psychotropic Prescriptions, Children in Foster Care by Age Cohort

- <1: $8
- 1 - 4: $253
- 5 - 12: $3,051
- 13 - 21: $2,546
- All: $1,809
Psychotropic Drug Utilization according to Number of Foster Care Placements

![Graph showing the average number of psychotropic prescriptions by number of placements. The x-axis represents the number of placements, ranging from 1 to 6, and the y-axis represents the mean number of psychotropic prescriptions, ranging from 0 to 3. The graph shows an upward trend with values: 0.81, 0.94, 0.87, 1.31, 1.94, and 2.68.]
Well Visits among New Entrants into Foster Care (n=542)

- 47% of children new to FC did not have a well visit in their first 180 days in FC
- Among children under the age of one:
  - 1/2 had a well visit during their first 30 days in FC
  - After 180 days, 82% of had a well visit
Change in Selected Services after entry into Foster Care among New Entrants in FY14 (n=127)
Conclusion

• Children in FC represent a particularly vulnerable population with unique needs and healthcare challenges

• This study was the first of its kind to examine the health status and healthcare utilization patterns among children in FC in Delaware. We identified three key areas of concern:
  – need for more attention on early screening and preventive health visits;
  – need to identify opportunities for better care coordination, particularly in relation to primary care and behavioral health; and
  – need to ensure continuity of care for children in FC system.

• Findings have implications for other children in DE at risk of neglect, abuse, or are otherwise connected with child welfare system

• Provides baseline to assess system improvements

• Represents an important partnership between Nemours, CCRS/SPPA, DMMA, and DSCYF
## Task Force Recommendations

<table>
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<tr>
<th>TOPICS</th>
<th>ISSUES</th>
<th>ACTIONS</th>
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| SCREENING    | Well-visits/screenings not done in a timely manner                     | • Standardize screening process  
• Investigate expanding Nemours pilot screening project to include all children upon entry into foster care  
• Provide trauma-informed care that assesses emotional, behavioral, and medical needs |
| ACCESS       | Lack of continuity of insurance                                         | • Provide training to caseworkers & foster care parents on accessing care  
• Develop policies & procedures to streamline access to care  
• Enable smooth transition of insurance coverage upon entry into and exit from foster care |
| CARE COORDINATION | Multiple physical and mental health services not adequately coordinated | • Create a position to provide central oversight & coordination  
• Educate families, caseworkers & providers on health care needs  
• Develop a psychotropic monitoring program |
| DATA         | Incomplete data tracking health services and outcomes                   | • Collaborate with University of Delaware to expand data analysis and develop outcome measures for ongoing monitoring  
• Create an expert committee to review data and implementation of task force recommendations |
Discussion/Questions

- Who needs to be at the table to make a decision about improving the health of children in foster care?

- How do we move towards better integrated behavioral and medical care for children in foster care?
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