A Toolkit for Building a Medical Home for Children Impacted by Child Abuse and Neglect

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1. **Forming a Planning Committee**

Prior to considering the creation of a program to meet the health care needs of children involved in child protective services in your area, you must find out what resources are already available for meeting the health care needs of these children. Gather data specific to your community around the number of children in foster care placement, in kinship care, or at risk of being placed outside the home. Find out which medical providers are currently serving these children. Find out if there is really a need for a program like this.

When you are ready to move forward, it is imperative that you identify "champions" for your project. This must include at least one individual affiliated with a medical provider and one from your County's child protection agency. These individuals must be willing to advocate for the program from within their respective organizations, and they must have the ability to influence decision makers.

In addition to a medical and child protection champion, it is helpful to have representation from your county's Department of Health (usually someone from the Health Care Program for Children with Special Needs) and your local mental health center. For practical purposes, it is helpful to have a "numbers" person: someone who can create budgets, figure out staffing patterns, and establish outcome measures.

Healthy Harbors began with a group of retired physicians and social workers talking about the problem. This led to a regular meeting and the start of planning committee. Soon, the project had a name and champions who were willing to bring it to the community stakeholders. Current members of the planning committee include representatives from:

- Physicians/Family Medicine Center and Salud
- Community Health Improvement Department at UCHealth
- Larimer County Department of Human Services (Child Protection)
- Larimer County Health Department (HCP)
- Touchstone Health Partners (formerly Larimer Center for Mental Health)
- North Beach Dental
- Colorado State University/School of Social Work
- Accountable Care Collaborative Leadership (UCHealth)
- Healthy Harbors Staff

2. **Decisions for the Planning Committee**

Once a solid planning committee has been established, there are certain decisions that need to be made and issues that need to be discussed. For Healthy Harbors, these included:

a. *Choosing a model that works for the community*. We did not want to form a new agency, so we had to find a larger organization that was interested in sharing our mission. For us, this came in the form of Poudre Valley Health System's Community Health Foundation. In Denver, there is a full health clinic that is run as a partnership between Denver Health and their child protection department. You need to decide early on how you can best utilize the resources available to you to build partnerships between agencies.

b. *Setting a vision and goals for the program.* Our goal has always been to improve the health outcomes of children impacted by child abuse and neglect via the medical home model. Healthy Harbors started within one clinic, the Family Medicine Center, with a part time navigator, and has since grown. But, our vision has remained the same. It is important to select a relatively clear vision of what the program can and will do, as it is easy to get swayed in different directions.

c. *Thinking about outcomes from the start.* When Healthy Harbors was finally launched, we had a clear set of milestones regarding how many children we would serve and what we would provide. We established methods to ensure that we tracked this information. As the program has grown, our outcomes have varied. But, establishing from the start, what the program can and cannot do is imperative.

d. *Staffing.* Healthy Harbors has always been primarily staffed by master's level social workers. As the program has grown, we have found that services can be provided efficiently by care coordinators at a bachelor's level. It has been helpful, in our community, to have social workers who can "speak the language" of child protection, but who are also comfortable with the fast pace of a medical clinic.

e. *Funding*. As with any program, funding is often the driving force around what services are provided and by whom. Our experience has been that obtaining grant funding during the start-up phase can give opportunity to demonstrate outcomes that can be shared with stakeholders. When you can show your local health providers and child protection professionals that your services actually save them money and improve health outcomes for their clients/patients, they

are likely to add support. This is one of the many reasons it is important to have champions and an ongoing oversight group, so that there is building awareness of the programs progress.

3. **Program Processes and Procedures: Healthy Harbors Toolkit**

    a. Referral Criteria

There are three criteria to become an official part of the Healthy Harbors program:

1) **The child should have (or have had) some type of DHS involvement.**
    - This could be out-of-home placement, a family assessment, or an emancipating teen.
    - DHS may close their case and the family can still work with Healthy Harbors.
    - In many kinship placements, DHS never officially opens a case. These families are eligible for Healthy Harbors services.

2) **The family should be willing to establish care at a medical facility where the navigator has built a relationship (Salud or FMC).**
    - The Family Medicine Center and Salud Family Health are currently the only official Healthy Harbors medical facilities. The goal is for Healthy Harbors to eventually be a community-based program where the navigator may go to any clinic the family chooses; however, during the pilot it is easier to track follow-up care if all patients are at one practice.

3) **The child should not already have an established primary care physician where they have been receiving routine and ongoing well-child care.**
    - If a child has been receiving appropriate care at another clinic, and the family is happy with their care there, they should remain with that physician.
    - Having just one or two appointments at another clinic does not constitute ongoing care; the navigator may explore with the family whether they would like to change practices.

When the program began, as funded by the Colorado Health Foundation, a “Healthy Harbors patient” was defined as a child who received the two following services: 1) the patient navigator collected information and compiled a health history template, and 2) the child participated in an intake appointment and the health history template was available to the doctor. Most children go on to have follow-up appointments (typically

around 30 days after the intake appointment) and continue to have contact with the patient navigator.

As the program has expanded to include children and clinics with varying needs, and the funding sources have expanded, these requirements have begun to evolve. While we still seek to collect and provide a thorough health history to providers, at times, this isn't necessary. This is generally because these children are already established in a medical home at either of our participating clincs, but require support around care coordination and navigation.

The navigator often receives referrals that do not fully meet the criteria to become official Healthy Harbors' patients (for example, they already have a primary care physician elsewhere). The navigator will make every attempt to offer referrals to appropriate resources in these cases.

b. Referral Process

This is the general process for children being referred to Healthy Harbors:

1) Navigator receives a call or email (usually from someone at DHS) asking to refer the child to Healthy Harbors. Referrals also come from the NICU, Corbett House, FMC and Salud, and, periodically, other agencies.
2) Navigator asks the referring party for basic information and fills out the Healthy Harbors Referral Form. (Attachment A)
3) Navigator contacts caregiver (parent/foster parent/kinship provider) and explores whether the child meets the three referral criteria.
4) If the child does not meet all three criteria, the navigator attempts to offer ideas or resources for their situation, asks if there is anything else they can do to help, and thanks the family for their time.
5) For children who will be establishing care at FMC, the navigator offers the family an intake appointment with one of the physicians.
6) Before the intake appointment, the navigator attempts to gather as much information about the child as possible, including:
    - Speaking to caseworkers about the reasons for DHS involvement, concerns, abuse/neglect history, case plan, etc.
    - Speaking to current caretakers about their observations and concerns
    - Speaking to biological parents (ask permission from caseworker first) about the child's medical history, family medical history, concerns, etc.
    - Requesting records from any previous medical providers (have the custodial party—usually someone from DHS—sign releases).
7) All of this information is compiled into the Healthy Harbors Health History Template. (Attachment B)

c. Intake Appointments

Our main goal, at the intake appointment, is to ensure that the child has a thorough medical exam with a provider who understands the special health care needs of children involved in the child protective system. Preparations for the intake appointment generally include:

- Providing the physician with a complete medical history for the child.
- Ensuring that all appropriate medical consents have been obtained from caseworkers or custodial parent.
- Addressing any barriers to attending the appointment, such as transportation, insurance issues, etc.

On the day of the appointment, the following procedures are folloed

1) Before the appointment, enter the Health History Template into the Electronic Health Record. This is under development as we adapt to EPIC.
2) Email the Health History to the provider (Donna Sullivan or Bernard Birnbaum) to tell them the Health History is available.
3) Greet the family in the waiting room, help them check in, and go back to the exam room with them. .
4) Wait in the hallway to huddle with the doctor before they see the patient. Briefly explain the patient's situation and any concerns.
5) Go into the exam room with the doctor. Assist the family in expressing their concerns. (Offer to step out during the exam if appropriate.)
6) Take notes about the doctor's recommendations, any referrals necessary, follow-up needed, and when the child needs to be seen again on the Appointment Tracking Log (Attachment C).
7) Help the family schedule future appointments at the front desk, if appropriate.

After the family leaves:

1) Make any referrals to community resources that were discussed.
2) Add to tickler calendar: any referrals to follow up on, any future appointments that the family will need to schedule
3) Send a brief email to the caseworker, if appropriate.
4) Document all interactions

d. Follow-up and Tracking.

Different navigators have different methods of tracking their work. Most of us use a tickler calendar of some sort. The purpose of the tickler calendar is to ensure ongoing follow-up communication by the navigator. Some examples of items on the calendar include:

- Reminders for future appointments. The navigator should contact the family about 3 weeks before the next required appointment.
- Reminders for the navigator to check on referrals that were made or records requested.
- Reminders for the navigator to periodically check in with the family to see how they are doing.

e. Confidentiality/Mandated Reporting

It is important to know the rules that govern confidentiality and mandated reporting in your community. The child protective system and the health care system have different laws that guide the information sharing that is possible. It is helpful to have a resource within both agencies that can help with complex situations. We use the attached Healthy Harbors Consent and Release (Attachment D) form, as well as the agency specific forms that are required by both the county and the health care system.

Healthy Harbors follows Colorado mandated reporting laws regarding suspected child abuse and/or neglect.

Healthy Harbors follows the Family Medicine Center and Salud guidelines regarding confidentiality and release of information.

f. Heath Passports

Because we use a medical home model, our goal is to have all the children in our program enrolled in comprehensive and coordinated health care. In many cases, children will continue as patients with our providers, and we will do minimal follow up, unless a need arises. In some cases, children move from foster care back to biological family care, and we attempt to stay engaged regardless of the caregiver/custody status. There are also times that children move from the area, and their medical care is transferred. In those cases, we provide the child and caregiver with a comprehensive Health Passport (see template, Attachment E) that contains:

- Healthy Harbors Health History
- Primary Care Provider Information
- Dental Provider Information
- Mental Health Provider Information
- Medical Specialist Information
- DHS Workers and Guardian Ad Litem Information
- Current Medication List
- Immunizations
- Allergies

- Former Medications
- Medicaid Number
- Health Action Plan (aka a TO DO LIST)

4. **ATTACHMENTS: Healthy Harbors Forms**
   A. Harbors Referral Form
   B. Healthy Harbors Patient Health History Template
   C. Healthy Harbors Consent and Release
   D. Harbors Appointment Log
   E. Healthy Harbors Health Passport

Healthy Harbors Referral Form

Child's Name	
DOB	
Who has custody? (DHS, bio parent, kinship provider)	
Placement Information: Name/Address/Phone	
Child's Caseworker	
Kinship/Foster Caseworker	
Name/Address/Phone of bio parents	
Any info about previous medical care	
Parents okay to attend appts?	
Referral source	
Date of Referral	

TO BE COMPLETED BY HEALTHY HARBORS:

- ¶Releases signed by person with custody (DHS worker, kinship provider, parent, or self for independent living teen)
  - for any previous medical providers
  - for dentist
  - for DHS, if DHS does not have custody

- ¶Intake appointment scheduled
- ¶Called people to get background information
- ¶Ordered records from previous medical providers
- ¶Compile Healthy Harbors Health History Template

Healthy Harbors Patient Health History

PATIENT IDENTIFICATION:

NAME:
DOB:
ETHNICITY:
BIRTHPARENTS:
FOSTER/KIN PROVIDERS:
DHS WORKER:
FOSTER/KIN WORKER:
GAL:
TREATMENT GOAL:
SCHOOL/DAYCARE:
OTHER:
Referral Date:

PREVIOUS/CURRENT HOME ENVIRONMENT (SIBLINGS, ETC)

MEDICATIONS:

PAST MEDICAL HISTORY:
Hospitalizations/Injuries:

Chronic Health Problems (including allergies):

Prenatal History (prematurity, maternal substance abuse, newborn issues):

Abuse History:

Family Medical History (medical, psychiatric, substance abuse, chronic illnesses, diabetes, heart disease):

Previous Medical Providers:

Educational History (schools attended, number of schools, school issues):

SOCIAL HISTORY
Tobacco use:

Alcohol use:

Drug use:

Sexual history:

Incarcerations/legal involvement:

Past and Present Housing Circumstances/Environmental Exposure:

CURRENT MEDICAL HISTORY:

Infections:

Nutrition/dietary issues:

Behavior problems:

Sleep problems:

Dental care:

Immunization records:

Psychiatric/Mental health care:

Substance use/abuse:

STD exposure risk:

Health History compiled by:
DATE:

Healthy Harbors Program

Consent to Participate, General Release of Information

I, _____, give consent for (child's name)_____ to participate in the Healthy Harbors (HH) program and receive care coordination services from a Healthy Harbors Coordinator through Poudre Valley Health System. I understand that the HH care coordinator may attend physician appointments with the above-named child, assimilate a health and social history when applicable, facilitate communication amongst multiple providers and agencies, and generally assist with other identified issues or challenges related to the overall healthcare of this child.

I also permit the HH Care Coordinator to share and receive information related to this child's medical and/or mental health conditions, social resources, educational needs, dental care, and community agency involvement with providers, organizations, or other professionals or individuals who provide care or services. Please refer to the Poudre Valley Health System **"Notice of Privacy Practices"**, which is included in the HH program paperwork, for detailed information regarding the use, disclosure, and access to protected health information (PHI). Health information is private and personal, and PVHS is committed to protecting it.

A copy of this authorization with my signature may be used with the same effect as an original.

_____ _____

Date of Signature Signature of Authorized Representative* or client

_____ _____

Date of Signature Signature of Witness (not required)

**If signed by an Authorized Representative:*

Print name and relationship to client: _____

Healthy Harbors Appointment Log

Patient Name	
Appointment Date	
Provider Seen	
Symptoms Noted	
Items Discussed	
Follow Up Actions Required	
Date of Next Appointment	
HH Navigator Name:	

Healthy Harbors: A medical home for children in Larimer County

HEALTH PASSPORT

Name:

Date of Birth:

MEDICAL PROVIDERS:

NAME:
PRIMARY CARE PHYSICIAN:
ADDRESS:
PHONE:
FAX:
DATES OF SERVICE:

MEDICAL SPECIALISTS:

NAME:
PRIMARY CARE PHYSICIAN:
ADDRESS:
PHONE:
FAX:
DATES OF SERVICE:

DENTAL PROVIDER:

NAME:
ADDRESS:
PHONE:
FAX:
DATES OF SERVICE:

MENTAL HEALTH PROVIDERS:

NAME:
PROVIDER:
ADDRESS:
PHONE:
FAX:
DATES OF SERVICE:

COORDINATED CARE PROVIDER:

NAME: Healthy Harbors
NAVIGATOR:
ADDRESS:
PHONE:

DEPARTMENT OF HUMAN SERVICES:

CASE WORKER:
PHONE:
EMAIL:

GAL:

NAME:
PHONE:
EMAIL:

MEDICATIONS:

IMMUNIZATIONS:

ALLERGIES:

FORMER MEDICATIONS:

MEDICAID NUMBER:

TO DO LIST:

Find a Primary Care Physician
Request Medical Records to be transferred from Family Medicine Center
Request Referral to Therapist and Psychiatrist from new doctor
Find a Dentist (schedule next check-up in September)
Remember to call Pharmacy one week prior to running out of medications
Remember to make a list of concerns prior to each medical appointment

PASSPORT PREPARED ON: