Whereas, The most recent estimation showed 424,000 children in foster care in the U.S. in 2019, which has stayed consistent since 2009; and

Whereas, American Indian/Alaska Native (AI/AN) children were disproportionately overrepresented in the foster care system by double their share of the U.S. population in 2020, are twice as likely as their White counterparts to be removed from their family, and more likely to have special health care needs; and

Whereas, Upon entering foster care, 30% to 80% of children have at least one physical health problem, 33% have a chronic health condition, 40% have significant dental issues, and up to 80% have a significant mental health need; and

Whereas, During foster care, 50% of children have healthcare needs which remain chronic or unmet and 30% of children with potential mental health needs went 12 months without intervention; and

Whereas, While in foster care, 50% of children are subject to at least one change of placement, and 20% move at least three times in one year; and

Whereas, Poor communication between caregivers, Child welfare services, and medical personnel results in 50% of children having discrepancies in identifying data that prevents their electronic medical record from being matched with their child welfare files, and more than 40% of those children lack a basic social history in their health record such as why they entered foster care; and

Whereas, Incomplete medical histories and frequent changes in physical custody lead to decreased continuity of care, causing the health needs of children in foster care to often go undiagnosed and untreated; and

Whereas, A “pediatric medical home” is a primary care model which provides a single home for medical records, maintains provider continuity throughout the childhood of a patient, and coordinates specialty care; and

Whereas, In 2016, only 40% to 50% of all children in the U.S. were reported to have access to a medical home; and

Whereas, Pediatric medical homes are associated with increased primary care utilization and improved health outcomes, making them ideal for children in foster care; and
Whereas, Computerized intersystem health information exchange platforms are associated with increased immunization and health record completeness, reduced care disparities, and increased overall quality of care; and

Whereas, Interagency information exchange results in more than a threefold increase in the likelihood of receiving needed behavioral health services for a child managed by child welfare agencies; and

Whereas, Several states have implemented computerized health systems to improve information exchange between child welfare agencies and health care services including The Texas Health Passport, Ohio IDENTITY, Pennsylvania UPMC for You, and California Foster Health Link; and

Whereas, Health care management services and designation of accountability for the health services of a child in foster care are associated with positive health outcomes and more than a threefold increase in likelihood of a child receiving needed health services; and

Whereas, Some states have implemented medical case management programs to longitudinally follow children in foster care including California and North Carolina; and

Whereas, The variability in infrastructure to address health needs of children in foster care between and within states suggests a need for standardization of care quality through state-level supervision; and

Whereas, The Indian Child Welfare Act (ICWA), enacted in 1978 to address the disparities in Native child foster placement, provides placements for AI/AN children that are conducive to longitudinal health care by requiring minimal Federal standards for their removal and placement of such children in long-lasting, culturally appropriate homes; and

Whereas, The American Academy of Pediatrics (AAP) recognizes that the ICWA protects AI/AN children and adolescents from disproportionate rates of child removal and negative health outcomes, and supports increased engagement with the Indian Health Service which provides medical care to AI/AN children; and

Whereas, The AAP recommends the use of pediatric medical homes, increased information exchange between child welfare and medical providers, and the appointment of a pediatrician to supervise state-level medical case management of children in foster care; and

Whereas, Our American Medical Association MSS policies support the health coverage of all children in foster care and the entire transferability of electronic health records data between independent healthcare systems (Enabling Contiguous, National Electronic Health Record Network 315.003MSS, Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System 60.037MSS); and

Whereas, Existing AMA policy encourages the use of medical homes, supports the use of health information technology in conjunction with medical homes, and advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care (The Patient-Centered Medical Home H-160.918, Principles of the Patient-Centered Medical Home H-160.919, Addressing Healthcare Needs of Children in Foster Care H-60.910); and
Whereas, No existing AMA policy addresses longitudinal continuity of care needs of children in foster care which remain unaddressed in spite of legal access to medical care for foster children\textsuperscript{30,31}; therefore be it

RESOLVED, That our American Medical Association support the construction of computerized health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and healthcare professionals (New HOD Policy); and be it further

RESOLVED, That our AMA promote existing pediatric medical homes which provide continuity of care to children in foster care (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the designation of medical providers, teams, and/or committees to longitudinally follow children in foster care (Directive to Take Action); and be it further

RESOLVED, That our AMA support the appointment of a pediatrician in each state with experience in child welfare to the position of state medical director of foster care health case management in accordance with AAP guidelines to ensure standards of care are met (New HOD Policy); and be it further

RESOLVED, That the AMA support the longitudinal stability and care of American Indian and Alaska Native children in foster care by promoting the Indian Child Welfare Act. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/12/22

REFERENCES:


**RELEVANT AMA POLICY**

**The Patient-Centered Medical Home H-160.918**

Our AMA:

1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;

2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;

3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule;

4. will advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform; and

5. encourages health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care.

Citation: CMS Rep. 8, A-09; Modified: CMS Rep. 03, I-18;

**Principles of the Patient-Centered Medical Home H-160.919**

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the
Patient-Centered Medical Home as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.
5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

**Addressing Healthcare Needs of Children in Foster Care H-60.910**
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.
Citation: Res. 907, I-17;

**Medicaid Coverage for American Indian and Alaska Native Children D-350.992**
Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located.
Citation: BOT Action in response to referred for decision Res. 102, A-06; Reaffirmed: Res. 221, A-07; Reaffirmed: CMS Rep. 01, A-17