



TRAUMATIC BRAIN INJURY – A COLLABORATION ON TBI SCREENING FOR CHILDREN AND YOUTH IN FOSTER CARE



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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Executive Summary

In 2019, the Washington State Legislature passed Substitute House Bill 1605, adding a new section to chapter 74.13 RCW that requires a report to the legislature by December 1, 2019. The new section requires the Department of Children, Youth & Families (DCYF), in consultation with the contracted health plan that provides health care coverage to children and youth in foster care, to evaluate:

- What traumatic brain injury (TBI) screening tools could be used with children/youth entering out-of-home care and the evidence base supporting those tools;
- Options to include TBI screening in existing screens or in regular health care appointments; and
- Recommended treatment actions for youth with a potential TBI as identified by the use of a screening tool, in keeping with health and behavioral health care and trauma-related best practices.

DCYF created a collaborative workgroup in response to this legislation. The workgroup included medical staff and administrative staff from the following entities.

Coordinated Care Washington (CCW), Apple Health Core Connections (AHCC)

The health plan contracted to provide physical and behavioral health care to children/youth in out-of-home care.

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Health Care Authority (HCA)

The state Medicaid agency contracting with AHCC.

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Department of Social and Health Services, Aging and Long-Term Support Administration (AL TSA), Fostering Well-Being (FWB)

The FWB program is housed in AL TSA and provides care coordination to fee-for-service children/youth including tribal children/youth who do not opt into AHCC coverage and undocumented children/youth who are not eligible for federally funded Medicaid programs.

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Additionally, the following legislative staff were invited to attend meetings in August and September.

House:

- Luke Wickham – Committee staff – Luke.Wickham@leg.wa.gov
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David Minor and Dr. Koblenz consulted with the Washington State Traumatic Brain Injury Council in regard to the workgroup activities.

Danielle Clark, Ph.D., a member of the TBI council and an advocate for TBI-related work, participated in one of the workgroup sessions.

Introduction

Traumatic Brain Injury (TBI) is defined by the Centers for Disease Control (CDC) as an injury to the brain due to a “bump, blow or jolt to the head that disrupts the normal function of the brain.”¹ There is a growing awareness of TBI in the general population, as well as a strong move toward prevention and appropriate treatment of TBI in populations where head injuries are more common, such as military personnel, the elderly and individuals who participate in athletics. There are widespread efforts to educate caregivers, school personnel and athletic personnel about TBI injuries, including the wide variety of short and long term effects of a brain injury.

Due to the growing awareness, interest in TBI screening has increased. In general, these screenings consist of a series of questions asked of a person after a known head injury to determine if the individual has any continuing physical or behavioral health symptoms as a result of the injury. Ideally, screening for TBI takes place before a known injury has occurred to establish a “baseline” functioning. Then in the event of an injury, the same screening tool is administered to assess for differences in the person’s responses that may indicate immediate effects of the traumatic event.

Health professionals have created multiple screening tools that attempt to discern if an individual has experienced head trauma and if any physical or behavioral health symptoms have resulted from that trauma. At this time, no evidence-based set of questions or screening tools accomplish this with any level of confidence.

In order to discuss TBI screening in the child welfare population, it is important to know how the Department of Children, Youth & Families (DCYF) addresses all areas of well-being for children and youth in out-of-home care. DCYF makes specific efforts to understand the complex needs of children and youth who enter the child welfare system. For each child/youth that remains in out-of-home care with DCYF for longer than 30 days, DCYF obtains the following:

- A Well Child Exam (WCE);
- Screening for emotional behavioral health needs;
- Appropriate behavioral health assessment(s) from community or specialized mental health professionals when concerns are indicated; and
- Prior two years of health records.

The caregiver and caseworker, with the support of the managed health care plan, can then follow the recommendations of medical and behavioral health professionals regarding any identified needs. During this physical and behavioral health assessment period, **TBI-related symptoms would be identified and treated by attending physicians, along with all other health symptoms and conditions.**

Children and youth who enter out-of-home care have a wide range of unmet developmental, physical health and behavioral health needs, that can include trauma related needs. Additionally, the symptoms of co-occurring physical and behavioral health concerns can overlap. For example, a child or youth could have both a history of trauma and a known history of TBI. In this example, it can still be challenging to determine if current symptoms existed prior to or were worsened by the injury, or are attributed to the trauma experienced by the child or youth, including the trauma of separation from family and placement into out-of-home care. Because of these complex needs, **it is imperative that children and youth in care receive medical evaluation and treatment from medical professionals** who can accurately identify their needs.

¹ CDC: Traumatic Brain Injury & Concussion

It is the goal of this workgroup to identify when a TBI screening or TBI-related questions might be valuable in meeting the needs of children or youth in out-of-home care. The workgroup attempted to identify medically sound strategies that are both possible and will have the best chance of identifying children and youth in out-of-home care with a TBI.

A Medical Review of Traumatic Brain Injury

TBI Definition

The Brain Injury Association of America explains that any damage to the brain that occurs after birth is considered an Acquired Brain Injury (ABI).² There are two types of ABI: non-traumatic and traumatic. TBI is considered a traumatic injury to the brain when an external force causes some alteration in brain function. TBIs can happen as a result of falls, motor vehicle accidents, assaults, sports injuries and more. Non-traumatic brain injury occurs after birth and is due to another physical condition, typically one that deprives part or all of the brain of oxygen. Some common causes of non-traumatic ABI are stroke, tumor, aneurysm and near-drowning. The focus of this report is on TBI and the identification of injury through screening and possible treatments for TBI.

TBI Data

The prevalence of TBI in the general population of the United States (including adults and children) is just under one percent (0.89 percent).³ According to 2018 data from the Washington State Health Care Authority (HCA), the prevalence rate for Medicaid enrolled children ages 0-17 is:⁴

- 0.1 percent – or one-tenth of a percent for the general Medicaid population, or 1.03 per 1,000
- 0.3 percent – or three-tenths of a percent for the foster care population, or 3.12 per 1,000

These rates are based on Medicaid billing data, which means the individual's medical provider submitted billing to Medicaid for a TBI-related condition during at least one medical exam in calendar year 2018. This data does not reflect the severity of the injury or if hospitalization occurred, and is only reflective of the population of children receiving Medicaid services. There is no way to determine why there is a slight difference in the rates between the general Medicaid and foster care Medicaid populations. A number of reasons could be speculated, including the neglect and abuse that brings children and youth into the foster care system, the smaller sample size of the foster care population compared to the general population or the quality of medical coverage for children and youth in out-of-home care. However, these are only speculations and without further research the reason cannot be discerned.

The CDC Injury Center compiled data for emergency department visits in 2014 where a known injury to the head occurred:⁵

- 48 percent of the TBIs were a result of falls
- 17 percent were a result of being struck by or against an object (including motor vehicle accidents)
- 9.86 percent were seen in children and youth related to sports or recreational activities where an injury to the head was known or suspected

² [Brain Injury Association: What is the difference between an acquired brain injury and a traumatic brain injury?](#)

³ Based on 2014 population data; resident population plus armed forces overseas; Dec. 2014: 320,201,099; Dec. 2018: 328,318,861. [Census Bureau FactFinder](#) and [CDC TBI: Get the Facts](#). CDC 2014 numbers for individuals with TBI + 2,870,000: compare with 2014 population data and we find that .89% of Americans had a TBI of some sort.

⁴ HCA data.

⁵ [CDC: TBI-related Emergency Department Visits, Hospitalizations and Deaths \(EDHDs\)](#)

TBI Symptoms

The severity of TBI injury and the resulting TBI symptoms can range from mild to severe and depends on the mechanism of the injury and part of the brain affected. According to the CDC,⁶ most TBIs that occur are mild and are commonly called concussions. The majority of people with a mild TBI recover from their symptoms in a short period of time (a few days to a few weeks). Individuals with moderate or severe TBI are the most at risk for symptoms that can last for months, years or a lifetime.

Serious or life-threatening TBI symptoms are treated in emergency rooms, with emergency surgery and/or through inpatient hospital care. Treatment for a severe injury focuses on stabilizing the individual, preventing further damage and preserving life. The symptoms for moderate to severe TBI require immediate medical care and can include but are not limited to the following:⁷

- Slurred speech, convulsions, seizures, loss of consciousness or memory loss
- Uneven pupils, blurry vision, blindness
- Weakness, numbness or decreased coordination
- Confusion, inability to recognize people or places or increased restlessness or agitation
- Persistent headache that does not go away
- Children who are inconsolable, will not stop crying or refuse to nurse or eat

Many TBI symptoms are less severe in nature and can be associated with any severity of TBI. These symptoms are treated with medications or therapies that are typical for the symptoms being experienced. Symptoms can include:⁸

- Difficulty thinking clearly, concentrating or learning/retaining new information
- Headache, sensitivity to light or noise, blurry vision
- Nausea or vomiting (early on)
- Feeling tired/having lack of energy, drowsiness
- Ringing in the ears, balance problems or dizziness
- Mood changes including irritability, sadness/depression, nervousness or anxiety
- Difficulty falling asleep or staying asleep, or sleeping more than usual

TBI symptoms manifest differently for each individual based on the severity of the injury, the part of the brain that was injured and the overall physical health of the injured person. The consulting doctors in the workgroup report that there is no single course of treatment or list of symptoms that all people with a certain type of TBI will have. For instance, one person may have sensitivity to light and mood changes, while another may have headaches and difficulty sleeping. The primary goal of treatment for any TBI is to manage the symptoms, which need to be individually assessed and treated by a medical professional.

For most people with a mild TBI or concussion, symptoms resolve within a couple of weeks.⁹ Physicians prescribe rest and a slow return to a normal routine for mild TBIs, which allows the individual to do what they can tolerate as they heal and eventually return to normal functioning.¹⁰ The consulting doctors expressed concerns that screening for a history of TBI where no injury is known may overly attribute TBI as the cause of current symptoms, when in fact TBI is not the cause.

⁶ CDC: [Concussion Recovery](#)

⁷ CDC: [Concussion Recovery](#)

⁸ CDC: [Concussion Recovery](#)

⁹ CDC: [TBI Publications, Reports and Fact Sheets](#)

¹⁰ CDC: [TBI Publications, Reports and Fact Sheets](#)

Individuals with a known TBI, whose symptoms do not resolve within a couple of weeks, should have a follow-up appointment with their physician to discuss post-concussion syndrome.¹¹ The Mayo Clinic defines post-concussion syndrome as “a complex disorder in which various symptoms – such as headaches and dizziness” can “last for weeks and sometimes months after the injury that caused the concussion.”¹² There do not seem to be predictive factors that indicate who will have symptoms after a head injury. There are some indications that people with post-concussion syndrome may share common factors such as underlying neurological or mental health disorders, post-traumatic stress disorder, family and social stressors, previous brain injury or learning delays.¹³

Trauma and TBI

There are confounding factors when attempting to identify the causes of physical and behavioral health symptoms for children and youth in out-of-home care. There can be preexisting developmental, physical health or behavioral health needs including emotional trauma that have a direct impact on the child or youth’s health status. Many of the symptoms for other physical and behavioral health concerns, such as emotional trauma, are difficult to differentiate from the symptoms of TBI. Medical and behavioral health professionals can assess the individual’s known history and current symptoms to determine the appropriate course of action.

Without a baseline, even if a head injury is reported and the mechanism of injury is known, it still requires careful medical evaluation to determine if a person’s current symptoms existed prior to the injury, were made worse by the reported injury or are attributed to their experienced emotional trauma, including the trauma of being in out-of-home care.

Emotional trauma-related physical and behavioral health symptoms can include but are not limited to:¹⁴

- Loss of memory, disorientation, intrusive memories, confusion, difficulty concentrating
- Mood swings, irritability, aggressive behaviors, depression, social isolation, anxiety, guilt
- Exaggerated or startled responses, hypervigilance
- Changes in sleeping or eating patterns, fatigue, insomnia
- Physical complaints such as general aches, stomachaches or headaches
- Avoidance of thoughts, feelings or places that trigger memories
- Detachment from other people and emotions, panic attacks

When we compare trauma and TBI symptoms, we can see a great deal of overlap between them. The overlapping symptoms include:

- Memory loss, confusion, difficulty concentrating
- Changes in sleeping patterns such as difficulty falling or staying asleep, or sleeping more often
- Mood changes including irritability, depression, anxiety or nervousness/startled easily
- Physical complaints such as headaches or lack of energy

The following table helps visualize the places where symptoms of emotional trauma and TBI overlap and where they do not.

¹¹ CDC: [Recovery From Concussion](#)

¹² Mayo Clinic: [Post-Concussion Syndrome](#)

¹³ CDC: [Recovery From Concussion](#) and Mayo Clinic: [Post-Concussion Syndrome](#)

¹⁴ NCTSN: [Trauma Screening](#) and Cascade Behavioral Health: [Symptoms, Signs & Effects of Psychological Trauma](#)

Symptom	Emotional Trauma	TBI
Loss of memory	X	X
Difficulty concentrating	X	X
Mood swings, irritability, aggressive behaviors, depression, social isolation, anxiety	X	X
Confusion	X	X
Exaggerated/startled responses	X	X
Changes in sleeping/eating patterns, fatigue, insomnia	X	X
Physical complaints: general aches/pains, stomachache, headaches	X	X
Avoidance of thoughts, feelings or places that trigger memories, or intrusive memories	X	
Detachment from other people and emotions, panic attacks	X	
Slurred speech		X
Uneven pupils, blindness		X
Loss of consciousness		X
Convulsions, seizures		X

The U.S. Department of Veterans Affairs, National Center for Post-Traumatic Stress Disorder (PTSD), has done a great deal of comparative study between PTSD and TBI. The National Center for PTSD states that diagnosing a TBI in individuals for whom both TBI and PTSD are possible can be difficult because there are not always physical signs of injury, and the signs and symptoms can overlap.¹⁵ Because of these overlapping symptoms, the National Center for PTSD suggests a medical professional is the best way to make diagnoses.

Similar to the population of veterans, children and youth in out-of-home care commonly experience trauma, and often it is trauma that rises to the level of PTSD (as diagnosed by a behavioral health specialist). Because trauma and mental health needs are so prevalent among children and youth in out-of-home care, there has also been a great deal of study on how trauma affects foster children and youth. In 2018, Washington State completed a five-year grant through the Administration for Children and Families Children’s Bureau¹⁶ focused on trauma symptoms of children and youth in out-of-home care. Based on data from this grant study, we know that approximately 27 percent of children and youth in out-of-home care in Washington were identified with trauma-related symptoms, and 63 percent had a mental health need identified upon entry into care.

According to the Washington State Department of Social and Health Services’ (DSHS) 2018 Behavioral Health Dashboard,¹⁷ 50 percent of the foster care population and 82 percent of foster youth ages 12-17

¹⁵ National Center for PTSD: TBI and PTSD

¹⁶ Kerns, S.E.U., Putnam, B., Davis, P., Pullmann, M., Benshoof, T., Jacobson, J., Uomoto, A. (2018). *Washington State Final Report*, Administration for Children and Families Children’s Bureau, Grant #90CO1103

¹⁷ Behavioral health dashboard [DSHS Children’s Behavioral Health Dashboard \(PDF\)](#)

have been formally diagnosed with a mental health treatment need. It is critical that physicians and licensed mental health practitioners evaluate and assess children and youth in out-of-home care so that we can accurately identify and treat their needs.

Screening for TBI

Questionnaires that gather information about head trauma and possible changes in physical or mental well-being because of the trauma are commonly referred to as “screening tools.” There have been a variety of these screening tools created that focus on TBI-related injuries. Some screening tools are designed to establish a baseline functioning pre-head injury for comparison during a post-injury re-screening to determine if there is evidence of a possible injury to the brain. Other screening tools are used in response to a known head injury to assess progression of functioning so that the individual can return to normal daily activities when their symptoms are manageable or resolved. Some screening tools attempt to gather historical information to determine if a head injury has ever occurred and if the patient has current symptoms as a result of a previous injury.

Common Types of TBI Screening Tools

Baseline Screening

There is a great deal of research supporting baseline screening of mental and physical functioning so that re-screening after a known head injury can determine if there is any change in cognitive, behavioral or emotional functioning. Baseline screening is common in sports where a head injury is more likely to occur such as football, soccer and other contact sports. Where screening demonstrates a change in functioning from the person’s baseline score to post-injury score, athletes are prevented from returning to the sport or activity until cleared by a doctor.

Baseline screening also helps distinguish between existing cognitive or emotional/behavioral concerns that are present prior to a TBI and new concerns identified after a TBI. Baseline screening allows medical providers to determine if an individual with a TBI has returned to their normal (baseline) state of functioning or if there are post-concussion concerns that need to be addressed.

The University of Nebraska used grant funding to examine routine brain injury screenings for preschoolers as a part of Well Child Exams (WCE) in pediatric offices. This effort was called the SAFE Child study¹⁸ based on the four sections of questions in the screener: Sickness, Accidents, Falls and Emergency Room (SAFE). The study found that routine screening for TBI as a part of WCEs may be effective in early identification of children at risk of future impairment from a known TBI.

The study stated that effective intervention after a TBI is dependent on parent report and timely re-screening after a head injury, as well as parent report of current symptoms that have occurred or worsened since the injury. The study was not able to identify the frequency with which children will have future challenges in cognition, development or psychosocial functioning as a result of a TBI, and stated that further research was needed in this regard.

Post Injury Functioning

Many tools are designed to evaluate a patient’s progress in recovering from a known TBI. The goal is to track progress and improvement in physical health, cognition and behavioral health in order to clear the patient for return to work or active duty.

¹⁸ SAFE Child: Screening Preschool-aged Children for Possible Brain Injury; University of Nebraska -Development of the **SAFE Child Screening Tool** was supported in part by TBI Implementation Partnership Grant #H21MCO67 58 from the Department of Health and Human Services (DHHS), Health Resources and Services Administration, Maternal and Child Health Bureau.

One such screening tool used by the Defense and Veterans Brain Injury Center (DVBIC), is the Military Acute Concussion Evaluation 2 (MACE 2).¹⁹ The MACE 2 is designed to be used by medically trained personnel to evaluate patients after a possible concussive event. MACE 2 is used as close to the time of injury as possible and can be repeated over time to track recovery progress.

Historical Self or Other Report

A self-report or parent/guardian report is the primary way information is collected during screenings for TBI. This is consistent across a range of screenings from parent/self-report screenings such as the SAFE Child screen to the MACE 2. These tools gather self or caregiver-reported information to determine first if a head injury has occurred and second, in the event of a TBI, if the patient is still experiencing symptoms.

The physicians and medical professionals consulted in the writing of this report stated that there are no evidence-based screening tools to reliably determine the history or presence of a TBI. The screening tools are more of an indicator that, given the report of a head injury, current symptoms may be a result of the head injury, especially if the individual can report that their symptoms have started or worsened since a reported injury. Further medical evaluation is required to make any determination of TBI or post-concussion syndrome.

The Child Welfare Population – Impact on Screening

Screening for TBI in the general population relies on a combination of accurate historical information and report of current changes in functioning since a head injury. For children and youth in out-of-home care, TBI screening is complicated by factors affecting the collection of accurate historical information from caregivers or legal guardians, including the following:

- Reliability and accuracy of information;
- Willingness of the parent/guardians to divulge information;
- Lack of historical information available in the absence of a parent/guardian;
- Time passed since the injury occurred;
- Lack of physical health care records prior to the injury for comparative functioning; and
- Trauma that children and youth have experienced prior to or during their time in out-of-home care.

There are additional concerns that self-report for adolescents may be inaccurate or missing important details. For example, a parent might tell a child they were “dropped on their head” as an infant in jest as a response to the child’s behavior. The child then adopts that statement as part of their medical history and believes they were dropped on their head, when in fact they were not.

The other confounding factor is the number of children and youth that enter out-of-home care with a history of emotional trauma and a wide range of developmental, physical health and behavioral health concerns. The symptoms from any or all of these concerns can overlap and be very difficult to attribute to a single diagnosis. For example: if a head injury is known and reported, it can still be challenging to determine if current symptoms existed prior to the injury, were made worse by the reported injury or are attributed to the child/youth’s experienced emotional trauma, including the trauma of being in out-of-home care. Because of these complex issues, child welfare relies on medical doctors to evaluate, refer and treat all physical health conditions for children and youth in foster care.

¹⁹ DVBIC: Military Acute Concussion Evaluation 2 (MACE 2)

The consulting doctors in the TBI workgroup expressed concerns that standardized TBI screening in the child welfare population will lead to over-identification of TBI as the cause of current physical or behavioral health issues. There are also concerns that having child welfare staff ask questions about one specific physical health issue will create an environment that overly attributes physical or behavioral health symptoms to a specific mechanism of injury when the same signs and symptoms could be a result of a variety of physical or behavioral health concerns. Additionally, since most mild TBI symptoms resolve in days to weeks, current cognitive or behavioral concerns are not likely the result of a historic mild TBI, and current symptoms could easily be mislabeled as being from a TBI rather than from the underlying condition(s) that existed prior to the TBI.

It is because of these complex issues that child welfare relies heavily on medical and behavioral health evaluation and assessment by licensed medical professionals and behavioral health practitioners to meet the needs of children and youth in out-of-home care.

Treating Children and Youth in Out-of-Home Care

The implementation of a single managed health care plan for all children and youth in out-of-home care, and the integration of responsibility behavioral health services into this health plan, has helped DCYF make great strides in meeting the needs of children and youth in care. Care coordination for all health needs can now happen seamlessly and with consideration for co-occurring physical health and behavioral health needs.

DCYF policy requires all children and youth who enter out-of-home care to see a medical professional (doctor, advanced registered nurse practitioner and/or osteopath) within the first 30 days of entering out-of-home care. This medical examination must occur regardless of known or unknown physical health concerns. This initial medical appointment is a WCE broadly, and for children enrolled in Medicaid these exams are covered as part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The goal of the EPSDT benefit is to screen children and youth early and often, in order to diagnose, treat and ensure they receive appropriate preventive, dental, mental health, developmental and specialty services.²⁰ According to 2018 DCYF data for children and youth remaining in care more than 30 days, 96 percent received an initial EPSDT or WCE within the first 30 days of placement.

Some children and youth enter out-of-home care with a known medical condition, which could include a TBI. When a child enters care with obvious or known signs of illness, disease or injury, they are seen in an emergency room or urgent care in response to their physical health needs. Regardless of the type of medical concern, the initial medical appointment and recommendations for treatment, medications or follow-up are documented by the provider and are then reported to the caregiver and caseworker. The managed health care plan for children and youth in foster care, Apple Health Core Connections (AHCC), is also informed of the child or youth's presenting medical needs. AHCC then provides medical and behavioral health care coordination based on all identified needs. In the event that a child or youth has a known physical health condition, including TBI, AHCC provides care coordination and caregiver education based on the diagnoses identified by the child or youth's medical provider and the level of physical health need of the child or youth.

For many children and youth entering out-of-home care, their general physical health history, including any knowledge of past TBI, is relatively or completely unknown and they do not present with any obvious physical health needs. These children and youth are still evaluated by a medical doctor in the first 30 days of out-of-home care. If any physical or behavioral health concerns are observed or reported

²⁰ Medicaid: Early and Periodic Screening, Diagnostic and Treatment

during the initial medical appointment, the child or youth will receive all needed assessment, treatment, follow-up and health care coordination.

In response to the complex needs of children and youth in out-of-home care, AHCC offers a wide range of supports to children, youth and caregivers based on their unique needs. AHCC also provides services to those in adoption support, young adults in extended foster care (ages 18-21), young adults up to the age of 26 who aged out of foster care at 18 years of age and reunited families up to one year after the child or youth returns home. The services include, but are not limited to, the following:

- Care coordination and disease management
- Care management for chronic health conditions
- Caregiver education and training
- Help to find local medical and behavioral health providers to meet the child or youth needs

In addition to care coordination and care management, AHCC has a website for caregivers that contains health information sheets on hundreds of topics that caregivers can access on their own. There are 23 health sheets on TBI-related topics alone, including such titles as *Caring for a Loved One with TBI*, *Physical Problems After Brain Injury* and *Behavior Changes after Brain Injury*. These resources are available to caregivers free of charge. AHCC is active in creating and delivering written materials and in-person training opportunities to caregivers, caseworkers and community medical and behavioral health partners as needed throughout the state.

Regardless of known or unknown physical and behavioral health concerns for children and youth in out-of-home care, there is a system of care available to identify and meet the needs of each child and youth and provide support to their caregivers.

Conclusion

It is difficult to identify historical physical health concerns in general for a child or youth in out-of-home care. It can also be a challenge to determine the root cause of current observable physical or behavioral health symptoms, even when there is a known mechanism of injury or identified illness. In the same way, it is difficult to attribute current symptoms to a known historical head injury, especially if the injury was not severe, since there may not be current symptoms. There can even be challenges with determining current effects from severe TBI without a knowledge of the patient's levels of cognitive and physical functioning prior to known injuries. In an attempt to discover an effective way of consistently learning of unknown TBI history for children and youth in out-of-home care, DCYF and the collaborative workgroup have explored a variety of ideas and options as possibilities.

The physicians and medical professionals consulted in the writing of this report have stated that there are no evidence-based screening tools to determine with reliability the history or presence of a TBI. In light of this fact, the workgroup is seeking to establish something that is effective and value-added to already existing processes with a focus on the medical provider community's expertise in diagnosis and treatment.

Two potential strategies are being explored for feasibility:

1. The addition of TBI-related questions to existing DCYF questionnaires for parents and caregivers regarding the health of their child or youth at the time of placement into out-of-home care. These questionnaires are used to inform DCYF staff and caregivers of a child or youth's health history and current needs when they first enter out-of-home placement. Adding TBI-related questions into existing practice will prevent over-identification of TBI as a specific concern, and include TBI in the array of physical or behavioral health concerns that a child may have.

2. The addition of a recommendation to perform TBI screening in the [Apple Health \(Medicaid\) EPSDT Program Billing Guide \(PDF\)](#). This guide is used by medical professionals to inform them about EPSDT program specifics and instructions on billing appropriately for services. Inclusion of TBI screening as part of the EPSDT provides a public health approach for this issue and creates a focus on TBI in a well-established medical exam that is a benefit for all Medicaid covered children not just children in foster care.

DCYF continues to explore these options through ongoing internal workgroup meetings and in consultation with HCA regarding Washington State EPSDT requirements. Additionally, DCYF is exploring ways to educate staff and caregivers about TBI and direct them to AHCC as a single point of contact for help in dealing with all physical health needs for children in out-of-home care.

Acknowledgments

DCYF thanks all the participants in the workgroup for contributing to this important task. Numerous doctors and staff contributed hours of analysis and behind-the-scenes conversations to support the daily work outside of meetings. These efforts allowed us to work toward medically sound and data-driven options that will be value-added for children and youth in out-of-home care. The partnerships we build together are what make us stronger and give the children and youth we are responsible for the best chance to thrive and succeed.