



January 19, 2015

The Honorable Joan Carter Conway, Chair  
Senate Education, Health and Environmental Affairs Committee  
Miller Senate Office Building  
2 West Wing  
Annapolis, Maryland 21401

The Honorable Peter Hammen, Chair  
House Health and Government Operations Committee  
House Office Building  
6 Bladen Street, Room 241  
Annapolis, Maryland 21401

Dear Chairwoman Carter Conway and Chairman Hammen:

We are writing to provide you with some additional information regarding our efforts to improve oversight of providers for medically fragile foster care youth licensed by the Department of Health and Mental Hygiene (DHMH) and funded by the Department of Human Resources (DHR). As noted in our January 8 correspondence, DHR and DHMH requested an independent medical review of the children placed with providers for medically fragile foster youth.

The enclosed independent report summarizes the medical review conducted by HealthCare Access Maryland's MATCH Program, in coordination with staff from the Mt. Washington Pediatric Hospital. Mt. Washington is an affiliate of the University of Maryland Medical System and Johns Hopkins Medicine and is well respected for the quality of care they provide.

The primary goal of the review process was to develop recommendations for enhancing the care and meeting the health needs of medically fragile youth in foster care and analyzed the medical records and treatment plans of all children placed at Second Family to assess the appropriateness of the level of care provided to each child. The review concludes that the children "are receiving excellent care and that their medical needs are being met" but also provides some recommendations to improve care.

Please do not hesitate to contact us should you have any questions about the report or if we can be of any further assistance.

Sincerely,

Handwritten signature of Theodore Dallas in black ink.

Theodore Dallas  
Secretary, DHR

Handwritten signature of Laura Herrera Scott in black ink.

Laura Herrera Scott, MD, MPH  
Acting Secretary, DHMH

### Medical Case Review of Children at Second Family Therapeutic Group Home

A team of doctors and nurses from HealthCare Access Maryland's MATCH (Making All The Children Healthy) Program and the Mt. Washington Pediatric Hospital, completed site visits between December 23, 2014 and January 5, 2015. The site visits included chart reviews and observations of the children. The primary goal of this review process was to develop recommendations for enhancing the care and meeting the health needs of medically fragile youth in foster care.

At the time of our review there were a total of 36 children placed at Second Family homes. Some children are voluntarily placed by caregivers who cannot manage their children's care in their homes (due to lack of adequate nursing support and/or behavioral issues). Other children are placed by the local Department of Social Services due to lack of available treatment foster care families (i.e. there was no TFC willing to accept the child or the TFC did not have a family that had the resources to care for the child). The children currently placed at Second Family have significant medical and/or behavioral conditions as summarized below:

26 children are medically fragile (requiring continuous nursing care for ADL's and medical equipment - 9 were vent dependent, 19 were g-tube dependent)

10 children are primarily with significant behavioral issues complicated by intellectual disabilities

29 children had REM (the other children were assigned to MCOs)

The number of prescribed routine medications ranged from 5-35 medications per child. The agency reported that they complete 3600 doctor visits per year.

We utilized a review tool that looked at the following domains:

- Nursing Care- plans of care were available and care was documented for nutrition, respiratory care, therapies, medical equipment/supplies, mobility/skin assessments, pain monitoring, personal hygiene, and physician orders of care
- Medications were charted, prescriber was noted, and refills were planned
- Emergency Plan of care documented and included MD notification and DSS notification
- Palliative Care plan (DNR or MOLST)
- Behavioral health plans were available and care/interventions documented
- Medical care including preventative care and subspecialty care documentation was reviewed

### Summary of Findings

Overall, we were very impressed with the care the children were receiving and with the extensive amount of documentation of care that was available. Below are comments about our findings and recommendations for improving the care documentation for oversight and planning purposes:

1. Nursing Care Plan, Physician Orders, and documentation of nurse activities
  - a. Level of nursing care of each child was not specified on any plan (i.e. this child requires 1:2 nursing ratio x 24 hours, this child requires 1:1 x 4 hours, etc.). The level of nursing care was definitely higher than any of these children would receive in a foster home- there is always someone awake and there is always at least one nurse (LPN) in the home.
  - b. Nursing care and interventions were documented in multiple places increasing the chance for errors and possible confusion. **Recommend simplifying nursing charting to one flow sheet per child that includes all of their care/orders** (i.e. feedings, respiratory care, bathing, skin assessments, repositioning, therapies like ROM, gait trainers, etc.)
  - c. Nurse supervisor review of flow sheets, medication records, and other therapies is not documented and should be done periodically to assure that care plans/orders are being followed. For example, if a child is suppose to be placed in a gait trainer once a week that should be documented clearly that this therapy occurred and a RN supervisor should review that this occurs. **Recommend RN supervisor review of flow sheets, medication records, and adherence to therapeutic orders on a regular schedule.**
  - d. Training on client specific medical equipment/procedures is not documented in the client's chart. **Recommend that staff names and training dates are included in the care plan where use of specific medical equipment/procedures is required.**
  - e. Physician orders look different for each patient/client (some typed on word document, some on physician order sheet). **Recommend using a uniform document for physician orders to reduce errors and make orders clear for staff.**
2. Medication tracking and charting
  - a. Medications are listed on several different documents resulting in possible errors in a list not being updated or accurate (esp. when transporting a child or in case of an emergency). The pharmacy printed MAR may be the most accurate but it also included reasons for medication that were inaccurate for some children (i.e. says taken for seizures but child does not have seizures so medication actually taken for behavior). **Recommend one master medication list and a documented process for medication reconciliation.**
3. Emergency plan of care
  - a. Not clear what definition of an emergency plan of care they are using- emergency plans basically just included demographic information and who to reach within DSS in case of an emergency (pertain to emergency transfer).
  - b. Medical emergency response by staff requires clear parameters for when to contact the next level of care (i.e. the supervising RN or the child's PCP or other subspecialist). Some children have "emergency" type of protocol written in a diagnosis specific nursing care plan, for example- Call 911 and then RN supervisor if seizure lasts > 5 minutes. Using a modified version of the pediatric emergency warning score could be an approach. **Recommend defining parameters (ex. Vital sign guidelines) for when to call supervisor and where to take patient for emergency care or when to call 911 as part of the emergency plan.**

- c. **Recommend improved Safe Environment Plans**- children with aggression and behavioral issues should have a safety plan that includes triggers/ interventions and preferences
- d. **Allergies should be posted**
- 4. Palliative Care plans
  - a. Many of the children placed at Second Family are very medically fragile with health conditions that will result in deterioration of their cardio-respiratory status and impact their life expectancy. **Recommend that DHR/DSS establish advanced directives including DNR/MOLST orders when appropriate for all medically fragile youth.**
- 5. Medical Care/Sub-speciality care
  - a. All of the children placed at Second Family required medical appointments with some type of sub-specialist. The majority of them saw a doctor at CNMC as their PCP but several saw other community doctors. PCPs should be monitoring orders and care plans every 3-4 months. **Recommend that Second Family establish a relationship with a complex care clinic to provide access to on-call doctors and care coordination with sub-specialist that may decrease the amount of medical appointments/ER visits.**
- 6. Behavioral Health Plans
  - a. Staff seemed comfortable handling youth's behaviors and for most of children with behavioral plans there was documentation of tracking behaviors and interventions. Many behavior plans were older than 1-2 years. **Recommend updating behavior plans more consistently and coordinating behavioral interventions with school.**

Second Family is providing a level care that is needed for both medically fragile children and behavioral complex children in our state. Overall, we feel that the clients are receiving excellent care and that their medical needs are being met. Care could be improved with streamlined and consistent formatting for documentation, more robust emergency and behavioral plans, and working with the guardians to establish long term care goals including advanced directives.