



# MEETING THE Health Care Needs of Children in the Foster Care System



## Framework for a Comprehensive Approach: Critical Components

The information provided in this publication is the result of a 3-year project conducted by the Georgetown University Child Development Center to identify and describe promising approaches for meeting the health care needs of children in the foster care system. In response to a national search for promising approaches, information was collected, on over 100 different approaches. Multiple publications representing the findings of the study are available.

Children in the foster care system have multiple and complex physical health, mental health, and developmental needs. To attend to these needs fully requires the creation of a very comprehensive, community-based health care system that includes a number of specific components. The list of “critical components” presented here evolved from several sources—learnings from states, communities and organizations that provide health care for children in foster care; consideration of national health care standards such as those developed by the Child Welfare League of America<sup>1</sup> and the American Academy of Pediatrics<sup>2</sup>; belief in the values embraced by systems of care that serve children with special mental health needs<sup>3</sup>; and the wisdom of the advisory group that assisted in analyzing the findings of this project.

As we studied approaches that states and communities were using to provide health care for children in foster care, we learned that many components of a comprehensive system were being implemented, but rarely did a single organization, state or community address all of the components presented below. This framework of critical components is presented here to provide states and communities a description of issues to consider when designing a comprehensive approach to health care for children in foster care. It is not intended to represent the only way to address these issues. Although policy development is not listed as a separate component within the framework, its importance was evident in our interviews. Implementation of these components is dependent upon strong child welfare and cross-system policies.



Georgetown University  
Child Development Center



<sup>1</sup> Child Welfare League of America (1988). *Standards for health care services for children in out of home care*. Washington, D.C.: Author.

<sup>2</sup> American Academy of Pediatrics. (1994). Health care of children in foster care, *Pediatrics*, 93(2), 335-338.

American Academy of Pediatrics. Committee on Early Childhood and Adoption and Dependent Care. (2000). Developmental Issues for Young Children in Foster Care, *Pediatrics*, 106(5), 1145-1150.

<sup>3</sup> Stroul, B.A. & Friedman, R.M. (1994). *A system of care for children and youth with severe emotional disturbances*. (Revised Edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

The comprehensive framework is not meant to be prescriptive, but rather to be thought provoking and to provide a range of ideas to discuss. We believe that consideration of a comprehensive framework will help states and communities assess their systems for providing health care for children in foster care, prioritize where to begin system change, and comprehensively address how to make improvements.

### **1 Initial Screening and Comprehensive Health Assessment**

An *initial health screening* is provided for all children as they enter foster care. This screening is used to identify health problems that require immediate attention. *Comprehensive health assessments* of children are conducted shortly after placement, at regular intervals during their stay in out-of-home placement, and as they reunify with their families or move to another permanent placement.

Assessments are conducted by qualified providers, in comfortable, accessible settings and are appropriate to a child's age, culture, language, and individual situation. Comprehensive assessments are more extensive than initial screening, and address a child's physical, dental, mental/emotional and developmental strengths and needs and focus on the child, the family, and the environment in which they live.

### **2 Access to Health Care Services and Treatment**

**Access**—Children are able to access both primary and specialty health care services. Strategies to ensure access are addressed, e.g., immediate eligibility for Medicaid, transportation, waiting lists, availability of providers who know and understand the needs of children in out-of-home care, location of health care services, levels of care to meet specific needs, medical necessity criteria specific to children in out-of-home placement, and payment sources for services.

**Services and Treatment**—Attention is given to providing a comprehensive array of health care services, from prevention to intensive intervention, that address the special physical, dental, emotional, and developmental health care needs of children in out-of-home placement. Family support services that enable caretakers to attend to a child's health care needs also are available.

### **3 Management of Health Care Data and Information**

Information about a child's health care and health status is gathered, organized, retained and shared in a way that assures the information is complete, updated regularly, and available to persons closely involved with the care of the child.

Health care history information about the child and family is gathered at the time of the initial placement. Relevant information about health care is transferred when the child leaves the foster care system. An organized method for documenting, storing, updating, and sharing health information about each individual child (e.g., through a health passport or a computerized information system) is in place. Health data related to individual children can be aggregated in order to determine system-wide needs, gaps in services, outcomes, and policies.

### **4 Coordination of Care**

Responsibility for coordination of health care is assigned to a specific person (e.g., a care coordinator or medical case manager) or unit of persons (health care management or liaison unit). A child health plan that documents health care needs, as well as services that are provided while a child is in care, is developed and followed.

**5 Collaboration Among Systems**

Health, mental health, child welfare, juvenile justice, courts, education, and other child-serving systems; providers; families; and community organizations collaborate to meet the health care needs of children in out-of-home care. This may be done in a variety of ways, e.g., through co-location of staff, sharing of financial resources, cross-system training, interagency collaborative service and/or planning teams, formal interagency agreements, etc.

**6 Family Participation**

Families—birth, relative, foster, and adoptive families—are viewed as partners in providing health care. They are involved as vital sources of information about the child’s health care history and needs, in the child’s ongoing health care, and to insure continuity of care in the transition from out-of-home care to permanent placements. A child’s health care is addressed in the context of his family’s strengths, needs, culture, beliefs, and environment. Families are included in planning, implementing, and evaluating strategies at the system level for providing health care. Families receive support services that will enhance their capacity to provide for their children’s health care needs.

**7 Attention to Cultural Issues**

Knowledge of the diverse cultures represented among the children and families in the child welfare system influences program development, creation of the provider network, training, and the design and delivery of health care services to meet the needs of children and families from these different cultures.

The approach incorporates an understanding of how people’s cultures and beliefs shape their view of health and illness. Traditional and non-traditional approaches to health care are offered.

**8 Monitoring and Evaluation**

Monitoring and evaluation ensure that the health care procedures developed for children in out-of-home placement are actually being followed. Health outcomes for children are tracked; family, child, and provider satisfaction are assessed; and cost effectiveness is examined. Improvements are made based on the results of this monitoring system.

**9 Training/Education**

Training is offered to parents, caregivers, health care providers, child welfare staff, and other child-serving systems. Training is individualized to fit the audience and may focus on issues such as: general health and developmental information, special health care needs of children in out-of-home placement, access to resources and services, health care policies and procedures, operation of the child welfare system, etc. Parents and caregivers participate as co-trainers, helping others to learn from their experiences. Specific training about how to meet an individual child’s special health care needs is provided for caregivers. Cross-system training is a vehicle for helping the child welfare and health care systems work well together.

**10 Funding Strategies**

State and community leaders understand how to use a variety of funding resources that are targeted for different aspects of health care, e.g., treatment services, care coordination, data management, administration, and training. Flexibility in funding strategies is encouraged, waivers are requested and different Medicaid options are pursued when necessary to assure comprehensive health care

services for children in custody. Child serving agencies enter into interagency agreements around the transfer of funds from one agency to another when needed to maximize funding resources.

## **11 Designing Managed Care to Fit the Needs of Children in the Child Welfare System**

When children in custody are included in publicly funded managed care plans, their special needs are addressed in the design of the managed care system, in contracts, in setting capitation and case rates, in the makeup of provider networks, and in developing special provisions. Special provisions might relate to eligibility, enrollment, authorization of services, medical necessity criteria, service array, data collection, provider rates, and tracking outcomes.

Mechanisms exist to solve problems that arise from managed care and to assure access, continuity of care (especially when children change placements), services for family members (in addition to the identified child), and understanding of the unique needs of this population of children and families. Training and ongoing support are offered to families to assist them in navigating the managed care system.



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### **Document Available From:**

Georgetown University Child Development Center  
3307 M Street, NW, Suite 401  
Washington, DC 20007  
(202) 687-5000 Voice  
(202) 687-1954 Fax  
Attention: Mary Moreland  
deaconm@georgetown.edu  
Also available on the web at [gucdc.georgetown.edu/foster.html](http://gucdc.georgetown.edu/foster.html)

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