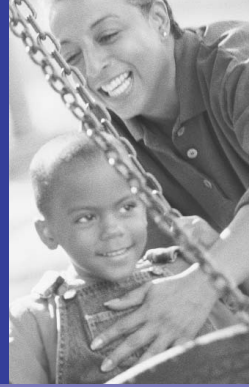




# MEETING THE Health Care Needs of Children in the Foster Care System



## S I T E V I S I T R E P O R T

# Arkansas Foster Care: Project for Adolescent and Child Evaluation

May 16-17, 2000

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.



Georgetown University  
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# Overview of the Approach

The **Project for Adolescent and Child Evaluation (PACE)** is a collaborative effort between the Division of Children and Family Services (DCFS) of the Arkansas Department of Human Services and the University of Arkansas for Medical Sciences (UAMS) Department of Pediatrics. The project seeks to remedy barriers to the provision of health care services for children in foster care, particularly the receipt of multidisciplinary, comprehensive health evaluations.

PACE provides the state-mandated comprehensive assessment to children and adolescents coming into foster care in Arkansas within 60 days of placement. Services are delivered statewide through a contract between DCFS and UAMS. Sixteen sites are served by roving assessment teams that include a developmental pediatrician, a psychologist/psychological examiner and a speech/language pathologist. Conducting the assessments at outreach clinics throughout the state allows for interface with community providers and provides a solution to the problem of having to transport children great distances.

Children or adolescents entering care are scheduled for a full team evaluation, which includes a vision screening, hearing screening, cognitive assessment, academic assessment, behavioral/emotional assessment, medical/developmental evaluation, speech/language assessment, and feeding assessment when appropriate. Evaluations typically last 4-5 hours.

Additionally, this approach aims to ensure that needed follow-up services based on recommendations from the comprehensive evaluations are received. At county-level offices, DCFS has approximately 20 Health Service Workers that interface with the PACE project and are responsible for obtaining recommended follow-up services. UAMS staff on the PACE project document the completion of follow-up recommendations by DCFS on a monthly basis. Reports are provided to individual staff in the Health Services Management Unit, Area Managers, and DCFS administration. An additional component of the PACE project was implemented in one county identified as having difficulty in follow-up on recommendations from assessments. In that county, a Patient Care Coordinator was added to the UAMS team to assist in coordinating followup care with foster parents and DCFS caseworkers.



# Background and Context

## Child Welfare System

The Arkansas child welfare system is operating under a consent decree that was to have ended in late 1999; however, it has since been extended for two additional years. Part of the consent decree addresses requirements related to health care for children in the foster care system. Among many other requirements, the state is charged with following the Child Welfare League of America (CWLA) standards on health care with respect to initial health screenings and comprehensive assessments and timelines. Initial health screens are to be conducted within 24 to 72 hours of entry into care. Comprehensive assessments are to take place within 60 days of entry into care.

A large majority of children in care are located in Pulaski County, and therefore workers in that area tend to have higher caseloads than in other areas of the state. Pulaski County is also the only truly urban area of the state.

## Health Care System for Children in Foster Care

As children enter the foster care system, they are presumed to be eligible for Medicaid. About 98% actually are determined eligible. Children covered by Medicaid have a primary care physician (PCP) who provides oversight for all medical services and makes referrals to specialists as needed. Services are provided on a fee-for-service basis, and there is no capitation arrangement. The DCFS central office houses a statewide behavioral health treatment unit. This unit deals with children who need special placements and determines how to pay for the placements.

After about 4 years of planning, Arkansas implemented a behavioral health managed care system for children in March 2000. Children in foster care were included in this system. An administrative services organization contract was awarded to Value Options, only to be cancelled 6 weeks after its start date due to failure to implement services successfully. At the time of the site visit, public child welfare and mental health administrators were working to determine how mental health services would be provided to children in foster care. Under discussion was a process that would require authorization or referral for services by the child's PCP.

## Population of Children in Care

DCFS served 5,100 foster children in fiscal year 1999. Approximately 2,600 children are in care at any point in time, with 700-800 new children entering care each year. Statewide, about 45% of children entering care are African American and 45% are Caucasian. A small percentage of children are Hispanic, some from migrant families. In Pulaski County, approximately 75% of children in foster care are African American.

## Health Issues for Children in Care

Mental health problems resulting from abuse and neglect were said to be a major health issue for children in care, as well as developmental impacts of parental substance abuse. The majority of children require mental health treatment. Another major problem is access to providers and specialized services,

particularly in rural areas, which make up the majority of the state. The state has a high teen pregnancy rate, and thus teen mothers and their babies may be entering care at the same time. Other health problems cited include asthma, dermatology problems, poor dental hygiene, language disorders, lack of immunizations, and weight problems.

# The Project for Adolescent and Child Evaluation (PACE)

## Rationale for Implementation

This approach was developed in response to the Angela R. Settlement Agreement, which took effect January 1, 1995 and required the State of Arkansas to undertake a major child welfare reform effort. PACE seeks to remedy barriers to the provision of health care services for children in foster care, particularly the receipt of multidisciplinary, comprehensive health evaluations. Barriers identified in the state prior to implementation of the approach included poor service access in rural communities, inability to get children to an assessment appointment, lack of knowledge to and from foster parents, and poor follow-up on recommendations for health care services. As statistics were collected pertaining to the lawsuit, it was discovered that only 20 percent of children coming into care in Arkansas had received a comprehensive health assessment. When children did receive an assessment, different aspects of the assessment often were not coordinated or conducted in one place.

DCFS approached UAMS in 1995 to develop a contract for providing comprehensive assessments for children entering care. The State wanted to achieve a uniform system for assessing the health and mental health needs of children in the foster care system, and wanted to ensure that all children received the same quality and level of evaluation within similar time frames. As a result of the consent decree, DCFS developed a policy that mandated comprehensive assessments within 60 days of placement, specified what should be covered in the assessment, and how follow-up was to be addressed.

Strategies for addressing health care of children in foster care were already being examined by a statewide working group beginning in 1992. That group included representation from DCFS, American Academy of Pediatrics, the Health Department, UAMS, health education centers, nurses, etc. When a new governor was elected, this group was disbanded; however, many of its recommendations were implemented as part of the reform. UAMS took the lead in developing the PACE approach, with buy-in from DCFS. Because most of Arkansas is rural and there are few providers in those areas, the approach developed by UAMS was designed specifically with that in mind.

## Implementation Process

Area DCFS offices scheduled unit meetings and full office meetings to discuss the PACE project and how to implement it. In retrospect, there was not a broad involvement in terms of input on initial implementation of the project. It would have been particularly helpful to involve field staff more in implementation—this would have reduced initial barriers and enabled referrals to come more quickly. For example, caseworkers were concerned about the logistics of the approach, and whether or not they could get to the scheduled appointments.

Early implementation issues included concern about the fact that some assessment sites were still too far from the children. Thus, the number of sites statewide was increased from 10 to 16. Also, there were many issues around the process for scheduling assessments. No-shows were a problem. This has since

been addressed through notification to each DCFS area of no-shows. Supervisors know whether specific workers, health care specialists, or foster parents have greater difficulty in getting children to the assessment appointments.

## **Funding for the Approach**

PACE services are funded through Medicaid as well as a contract between DCFS and UAMS utilizing general state funds. The contract is currently funded at \$938K per year, and covers administrative costs of the approach (site rental, etc.). It is renewed yearly, with UAMS returning any unspent funds at the end of each year. The contract is sufficiently funded, which enables the program to run well. Only once has it been cut mid-year, and it has been increased when needed to make improvements in the program.

Salaries for clinical staff are not part of the contract between UAMS and DCFS. The UAMS Department of Pediatrics pays the clinical salaries, and relies upon Medicaid reimbursement to cover these costs. An enhanced Medicaid rate was obtained for the assessments in order to make the program cost-effective for UAMS. In addition DCFS covers the costs for “no shows” and for children not eligible for Medicaid.

Under Arkansas’ Medicaid program, each child’s primary care physician (PCP) must approve appointments with specialists. However, the State Medicaid office agreed to waive the PCP requirement for purposes of conducting the comprehensive assessments. The PACE project director was able to work out this arrangement with Medicaid because of the provisions of the lawsuit. When completing an assessment, the PACE project has agreed to collect information on testing/services the child may have recently received, and not to repeat them. Also, they have agreed not to do certain in-depth testing unless a child does not pass initial screening tests. Medical recommendations resulting from the comprehensive assessment go through the PCP for approval.

## **Administration and Staffing**

The project is staffed by the following individuals:

- 1 Project Director (Speech Pathologist)—95% time
- 7 Pediatricians—up to 60% time
- 5 Speech Pathologists—3 at 100% time, 2 at 20% time
- 4 Ph.D. Psychologists—10% to 25% time
- 6 Psychological Examiners—20% to 100% time
- 10 Support Staff—100% time (including a Research Assistant and a Patient Care Coordinator)
- 2 Support Staff—60% time

The staff comprises several comprehensive assessment teams, some based in Little Rock at UAMS, and others based elsewhere in the state. Each team consists of a speech pathologist, pediatrician, psychologist/psychological examiner, and a secretary. Two of the teams are subcontracted through other agencies.

# Components of the PACE Approach

## Assessment Sites

Sixteen assessment sites were strategically placed around the state, based on where children are coming into care. Four of the sites are “fixed” in facilities. Other sites are serviced by a “roving” assessment team that travels from Little Rock.

Different regions of the state are served by different assessment teams:

- North East (subcontract team)—staff are based in the region; clinic operates one day/week
- East Central (subcontract team)—staff are based in the region; clinic operates one day/week
- North West—staff are based in an area that covers two regions; clinic operates three days/week
- All other sites are staffed by Little Rock teams that travel

Assessment sites are generally existing health facilities such as clinics, hospitals, health centers, or schools. The traveling assessment teams transport all of their equipment with them as they move from site to site. Vans were purchased to facilitate this travel.

## The Assessment Process

### Scheduling an Assessment

When a child comes into care, the DCFS health service worker is notified, and then contacts UAMS to schedule an appointment for the assessment. UAMS staff attempt to be flexible in accommodating the caseworker’s as well as the foster parent’s schedules. Thus, appointment times frequently have to be changed. If a child needs immediate attention, UAMS schedules the appointment as early as possible within the 60-day window.

In some areas, there was a breakdown in communication in terms of notifying UAMS when a child entered care. The UAMS project director now has access to the DCFS computer system, allowing her to cross-check lists of children entering care, to ensure that all assessments occur in a timely manner.

### Comprehensive Assessment

Children or adolescents entering care are scheduled for a full team evaluation, which includes a vision screening, hearing screening, cognitive assessment, academic assessment, behavioral/emotional assessment, medical/developmental evaluation, speech/language assessment, and feeding assessment when appropriate. Similar areas are addressed in all assessments; however, more in-depth assessments are done in specific areas if there are existing problems. The team has access to a battery of assessment instruments from which to choose, depending on the age or developmental stage of the child.

Typically, four children are seen by the assessment team in a day. The total time spent per child averages 4-5 hours. The process of obtaining information about the child during the assessment is made more difficult if the child has been taken to the appointment by a DCFS transportation worker, rather than a parent.

Components of the assessment include:

**Developmental Pediatric Evaluation**—This evaluation consists of the pediatrician conducting an interview with someone who knows the child. Medical records that have been gathered from DCFS are reviewed. A complete physical examination is performed. No pelvic examinations are conducted on teen girls, but if appropriate, a follow-up is recommended with a primary care physician. Except for one site, no blood work or immunizations are done. A dental screening is completed by the developmental pediatrician and the speech/language pathologist.

**Speech and Language Evaluation**—The speech and language evaluation consists of a hearing screening, which is done using a portable machine. If problems are noted the child is referred to the primary care physician or specialist for further evaluation. The speech and language evaluation also looks into receptive/expressive language, articulation, voice, fluency, and oral peripheral examination. A vision screening is also conducted.

**Psychological Evaluation**—The psychological evaluation consists of assessment of cognitive functioning, achievement, behavioral/emotional, and other areas (e.g., additional behavioral emotional tests). In addition, previous psychological testing is considered and attempts are made to obtain written records of the testing.

When the assessment is completed, the team provides verbal feedback to whomever attended the assessment with the child. The caseworker must give permission for the team to share information with birth parents. Whoever brings the child to the assessment is considered the DCFS representative and can hear the results.

Immediately following the assessment, the team meets with the child's caseworker and foster parents (if they attended the assessment) to review the testing and make recommendations for follow-up services. DCFS forms are completed, including a treatment plan form and a 10-15 page report. Office staff also attempt to track down the child's previous health records to include in the report. PACE staff recommend that foster parents record the information in the child's health passport, but they find that passports in the state are seldom utilized. In providing recommendations for follow-up care, PACE staff attempt to identify providers within the community for the child to see.

### **Follow-up to the Assessment**

UAMS e-mails a summary of the assessment to DCFS immediately and sends a full typed report through the mail within 14 days. (It takes the contracted assessment sites longer to send the full reports.)

DCFS health service workers are responsible for coordinating follow-up care. This care has to be accessed through primary care physicians (who make the referrals), but the PCPs, as yet, have not been asked to be responsible for assuring follow-up care is received. Further mental health services are recommended for about 60% of the children who are assessed. This is significant since 25% of the children coming into care are babies and there are no mental health recommendations for them.

To determine whether follow-up care is taking place, a UAMS evaluator randomly selects a sample of 60 cases each month for review. The process involves obtaining verification from the health service worker about the status of each follow-up recommendation listed on the assessment reports. (UAMS follows

cases for 90 days after the assessment is completed.) As a result of this review process, it was determined that follow-up on recommendations was extremely low in Pulaski County, and that this was keeping down compliance statistics for the entire state.

In order to address the follow-up problem in Pulaski County (which was attributed to a work overload for health service workers in the area), UAMS proposed to hire a Patient Care Coordinator who would assist in obtaining follow-up services for children in the county. The UAMS Patient Care Coordinator sets up routine appointments related to the recommendations and notifies the child's caseworker. The DCFS caseworker is responsible for coordinating transportation to appointments. Since implementation of this accommodation, compliance statistics for Pulaski County have greatly improved.

## **Family Involvement**

The consent decree requires that foster parents attend medical appointments, including comprehensive assessments, for children in their care. The state computerized data system has a field to indicate whether the foster parent attended the assessment, and recent data indicated approximately 50% compliance. An informal survey of foster parents revealed that barriers to attending appointments included work schedules, distance, and having other children at home to care for. PACE project staff speak at regional foster parent meetings about health issues and the need for foster parent involvement from the beginning.

Birth parents are not required to attend medical appointments, but the PACE team would like for them to be involved in the assessment process. However, this is left to the discretion of DCFS. Birth parent participation is not tracked. Problems were described with respect to getting foster parents to work collaboratively with birth parents around a child's health care.

Members of the assessment team felt that they are able to do a better job with assessments when both foster parents and birth parents participate. They have access to more medical information and health history this way. While birth parents are welcomed as participants, problems arose when the assessment appointment was being utilized by DCFS as a visitation appointment as well, thus detracting from the assessment process. Foster parents are provided the full written report resulting from the assessment. Birth parents receive a report if deemed appropriate by the DCFS caseworker.

Attitudes toward and involvement of birth and foster parents was found to differ by county. Some area workers almost always have foster parents at the assessment, others don't inform them about it. Some DCFS health service workers felt that birth parents are out of the picture and don't care about the children's medical issues. Others advocated for birth parents to be involved and attend medical appointments. The health service worker relies on the caseworker to determine the role of the birth parent. Family involvement was viewed as a leadership issue—if administrators viewed family involvement as important, then caseworkers tended to as well.

## **Cultural Issues**

The population of children in care in Arkansas is not particularly diverse. Ninety percent of children are either Caucasian or African American. In Pulaski County, approximately 75% of the children served are African American.

Members of the assessment teams are predominantly Caucasian. They considered themselves to be culturally competent and felt that cultural differences were considered during the assessment process. Certain speech/language assessment tools were mentioned as not being appropriate for the African American population. Spanish interpreters are utilized in the small number of cases of children from migrant families. Sign language interpreters are also available.

## **Training and Education**

The UAMS project director provides ongoing training for foster parents and for caseworkers about the PACE project as well as about the special medical needs of children in foster care. At the quarterly meetings of the DCFS health service workers, the project director and assessment team often provide training. Separate from the PACE project, DCFS has a contract with the University of Arkansas, Little Rock to provide ongoing training for DCFS staff on issues such as health, mental health, crisis intervention, etc.

In Pulaski County, DCFS supervisors are expected to train new caseworkers in the operations of PACE as they are hired. This is feasible now, since the turnover rate among staff has been reduced. In other areas of the state, the health services worker trains new workers about the PACE project and also trains foster parents regarding the procedures and children's health care needs.

## **Monitoring and Evaluation**

Two main compliance issues are tracked by the UAMS team:

1. The percentage of children receiving a comprehensive assessment within 60 days;
2. The percentage of follow-up recommendations completed.

UAMS reports that 80-90% of children are now receiving comprehensive assessments and appropriate follow-up care. Data are tracked by each area of the state so that statistics may be compared, and strategies implemented to address problem areas. In order to examine data on follow-up care, a random sample of 60 cases each month is selected in which comprehensive assessments were conducted three months earlier. DCFS is asked to provide documentation of completion of the recommendations. A UAMS research assistant is responsible for obtaining the data from the DCFS health service workers in each county. Monthly and quarterly reports of the results are then sent to DCFS staff and administrators.

As mentioned previously, the evaluation process revealed that, for the most part, follow-up services were being received. The exception to this was in Pulaski County. In this county, DCFS caseworkers and health service workers were having difficulty keeping up with the workload that was required. As a result, a Patient Care Coordinator (with experience in the health care field) was added to the UAMS team to assist with the process of obtaining follow-up on service recommendations.

PACE has not aggregated data received from individual child assessments for purposes of tracking health issues of children coming into care. They are setting up a planning unit to do this and believe that they can do it in the future. For now, they are only looking at compliance with completing assessments within 60 days as well as receipt of follow-up services. Also, it is hoped that eventually they will be able to download information about the medical services provided into each child's electronic file, but this process is not yet in place.

# Summary of Learnings from the Site Visit

## Strengths and Benefits

- Children are now getting the comprehensive health assessments they need within 60 days of entering care. The percentage of children receiving these assessments is now nearly 90%, whereas it was less than 20% before the approach was implemented.
- The percentage of children receiving recommended follow-up care is increasing, although compliance with follow-up recommendations is variable in different areas of the state.
- The approach is helping caseworkers to understand areas that children need help with, for example, developmental issues that need to be addressed. Foster parents and caseworkers are better able to meet children's needs.
- Caseworkers are very appreciative of the approach and feel that it is working well. DCFS staff feel that the PACE team understands the kinds of children/families DCFS works with, that they listen well, that the information obtained from the assessment often confirms their suspicions, and helps everyone understand the child better (family, school, judges, DCFS).
- There are multiple assessment sites around the state.
- The assessment teams are multi-disciplinary.

## Essential Elements of the PACE Approach

- There is a strong **fiscal commitment** at the state level to make the approach work and ensure that it is adequately funded. The fiscal elements of this commitment include:
  - a contract arrangement that covers UAMS administrative costs
  - enhanced Medicaid reimbursement rate to cover the costs of assessments (including salaries of the administrative team)
  - the contractor is reimbursed for “no shows” out of DCFS funds
  - annual review of the contract, with flexibility to increase funds when needed (for example, to add funds for the hiring of a patient care coordinator in Pulaski County)
  - contractor returns any unspent funds at the end of each year
- The consent decree mandated action, and the state now has a **policy** in place stating the time frame for conducting comprehensive assessments, the content of the assessments and the requirement for follow-up
- Open **communication**—willingness to discuss the good and the bad, and to correct any problems as soon as possible (quarterly meetings between DCFS, UAMS, and the health services workers are very helpful; project director spoke individually to each Pulaski Co. supervisor and attended and presented at foster parent meetings)
- **Collaborative approach**/good working relationship between DCFS and UAMS
  - UAMS has worked collaboratively with DCFS, rather than “taking over” the approach on its own
  - The UAMS project director is very accessible
  - DCFS/UAMS are willing to problem solve and deal with disagreements
  - Recognizing the imperfections of a state system, UAMS attempts to be flexible, cooperative, and helpful

- DCFS respects the competency of UAMS assessment teams
- Clarity on each party’s roles and responsibilities
- Attention paid to **follow-up**—assessment alone is not enough (including follow-up recommendations as part of the assessment; implemented formal process to monitor whether follow-up occurred)
- Strong **leadership** of the project director has been critical to the project’s success. (Determined to make it work, to try new strategies when there are problems)
- **Flexibility**—willingness on both ends to make changes/improvements when things are not working (for example, increased the number of assessment sites around the state from 10 to 16)
- Staff **commitment** and dedication; also persistence
- Positions of 20 DCFS **Health Service Workers/Health Care Specialists** in county offices throughout the state (they provide information about health issues to caseworker, remind them of appointments, help to coordinate care, etc.)

## Barriers and Challenges

- Workload for caseworkers is an issue—there is a need for more health service workers at DCFS offices.
- It is difficult to get all of the DCFS health service workers together quarterly to discuss issues.
- Some caseworkers are reluctant to involve foster parents in the assessment process. Communication with foster parents needs to be improved so that they can attend the assessment.
- Some caseworkers don’t see the value of assessments or of follow-up services that are recommended.
- There was a problem with lack of communication regarding appointments. This has been resolved through the use of e-mail and reports that the project director sends on a regular basis to update supervisors, workers, and health specialists.
- There is a lack of medical information available when children come into care (e.g., middle of the night placements). Information about eating habits, birth weight, medications would be helpful.
- Assessments cannot be completed in a timely manner if the child is admitted to a psychiatric hospital, a detention center, or is a runaway.
- It is difficult to obtain mental health and dental follow-up.
- Lack of specialty providers in some areas; lack of providers in rural areas.
- Not enough flexibility in appointment setting. Caseworkers have to deal with youth who run away and other emergencies that come up.
- Too many times the informant who brings the child does not know the child (e.g., transportation worker). This is especially significant for small children or children with mental retardation who cannot self-report.
- Some recommendations on the assessments are too generic and therefore it is difficult to know what should be done. Staff feel they have to “cover themselves” by following up on all recommendations, but may not know what is really expected. Or the recommendations are beyond the scope and power of the social worker to follow-up on, e.g., a school system responsibility.
- Initially, Pulaski County had difficulty meeting the expectations of the PACE project—difficulty getting the assessments scheduled within 60 days, getting foster parents to bring the children, and following up

on recommendations. The Pulaski County statistics were bringing down the rest of the state in response to the consent decree. So a special accommodation has been made for Pulaski County. (See below under Strategies.)

- Urban areas have larger caseloads, staff who have been there a long time and are less interested in changing the way they do things.
- Some children move in and out of care so quickly that the identified problems are not addressed.

## Strategies for Addressing Barriers

- DCFS is charged with paying for no-shows, not Medicaid. This pressured them to address the issue. No-shows and follow-up on recommendations are reported by DCFS area and by the individual health service worker. These reports are published for all to see—this encourages compliance.
- Provide training to help DCFS workers and foster parents understand the importance of the assessment process and health issues.
- UAMS has worked hard to be flexible, e.g., they added an extra clinic (with no additional funds); they scheduled 5 assessments instead of 4 in one day; they offer foster parent training, even though this is not in the contract.
- UAMS has changed the format of the assessment report so that it is more user friendly. They have also worked on writing clearer and more specific recommendations.
- Accommodation for Pulaski County: Recently, DCFS provided funds to UAMS to hire a patient care coordinator (PCC) to work directly with Pulaski County staff and foster families. Before the assessment occurs the PCC collects medical records and provides them to the assessment team.

## Recommendations and Advice for Other States and Communities

- Thorough assessments are needed to help DCFS make recommendations for future placement. Caseworkers do not know the child well enough without these.
- Have a unit or individual whose role it is to identify all children who have come into care and to forward this information to the person scheduling assessments. (Or make sure placement units notify health specialists as soon as possible when a child comes into care.)
- Direct communication is key. Everyone must share their observations about a child. Life threatening situations can occur otherwise. If there are communication breakdowns, follow-up does not take place. It is important that children in foster care be viewed as children of the full community, not just of DCFS.
- Build on the experience with the PACE project as a collaborative strategy for dealing with other problems, e.g., why children in foster care are having multiple placements.
- Implementation would have been easier if they had involved foster parents and the state agency field staff more in the planning of the PACE project.
- Have one main contact person at DCFS, not multiple ones. This has helped UAMS.
- Be willing to change something that isn't working well. Don't be too wedded to the original design. Use feedback from the people who use the system. (UAMS made major changes in the format for the written report and in the way they wrote recommendations.)
- Understand the roles and responsibilities of each entity involved in the process.

- Persons who accompany children to the assessment should know them and have medical background information.
- Communication with foster parents is critical. Also, make sure that the assessment report follows the child to his/her next placement.
- Composition of the assessment team should fit the needs of each county, e.g., the Pulaski team needs OT/PT on the team—not so in other areas of state.
- Need to have special funding mechanism so that the assessments can be billed to Medicaid at a rate that covers the costs.
- Communicating to supervisors, workers, and foster parents about the importance of follow-up helps to increase it. Also, publishing reports that show progress in follow-up by each area of the state, by individual health specialist and health service worker, encourages compliance.

# Appendix A: Project for Adolescent and Child Evaluation

## Site Visit Interviews Conducted

### Arkansas Division of Children and Family Services (DCFS)

#### State Level

- Foster Care Manager
- Assistant Director

#### Pulaski County (Little Rock)

- Area Manager
- Family Service Worker Supervisor
- Family Service Worker Specialist
- Health Service Worker

#### Jefferson County (Pine Bluff)

- Jefferson County Supervisor
- Social Service Worker
- Family Service Worker Supervisor
- Family Service Worker Specialist
- Health Service Worker

#### Drew County (Monticello)

- Family Service Worker Specialist
- Health Service Worker
- Health Care Specialist (RN)

### University of Arkansas for Medical Sciences (UAMS)

#### PACE Project Director

#### Assessment Team Members

- Pediatrician
- Speech-Language Pathologist
- Psychological Examiners

#### Patient Care Coordinator

#### Research Technologist (data manager)



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