

MEETING THE *H* Health Care Needs of Children in the Foster Care System



SUMMARY OF STATE AND COMMUNITY EFFORTS KEY FINDINGS



Georgetown University
Child Development Center



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

**Summary of State and
Community Efforts**

Key Findings

Prepared by Jan McCarthy
*Georgetown University
Child Development Center*

SEPTEMBER 2002

Supported in part by project #MCJ-11OH01-01-0 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services. Supplemental support was provided by the Children's Bureau, Administration on Children, Youth, and Families of the Administration for Children and Families in the U.S. Department of Health and Human Services, through a cooperative agreement with the Child, Adolescent, and Family Branch, Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration.

The document reflects the findings of a research project, as well as the thinking of the project advisory panel, respondents in states and communities, and the authors. It does not necessarily represent official policy or positions of the funding sources.

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

Notice of Nondiscrimination

In accordance with the requirements of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and implementing regulations promulgated under each of these federal statutes, Georgetown University does not discriminate in its programs, activities, or employment practices on the basis of race, color, national origin, sex, age, or disability. The statutes and regulations are supervised by Rosemary Kilkenny, Special Assistant to the president for Affirmative Action Programs. Her office is located in Room G-10, Darnall Hall, and her telephone number is 202/687-4798.



Acknowledgements

The author would like to recognize and thank the many knowledgeable and helpful people involved in this study and in the development of this document. It was the vision of the *Public-Private Partnership for the Health of Children in Out-of-Home Care* (supported by the Maternal and Child Health Bureau and the Administration for Children and Families) that led to the recommendation to undertake the study. Dr. Phyllis Stubbs-Wynn of the Maternal and Child Health Bureau provided leadership for the *Partnership* and as the federal project officer for the study. Initial project funding came from the Maternal and Child Health Bureau, with supplemental support in the later stages of the study from the Administration for Children and Families.

The individuals who participated in phone interviews and site visits provided the substance for this document. They told us what they were doing and why they were doing it. They explained what worked and what did not. Their frank and thoughtful reflections, as well as their advice to other states and communities, are important aspects of this report. Most of all, they continue to provide leadership in their own states and communities for meeting the health care needs of children in foster care. We thank them for taking the time to share their experiences.

The wisdom of a very hard-working advisory panel was essential in helping to define the focus of the study, recommend sites to visit, analyze the data and information that was collected, conceptualize the comprehensive framework described in Chapter 3 of this document, note emerging themes, and recommend strategies for presenting and disseminating study findings. Panel members represented the child welfare, health care, mental health, and juvenile justice fields; a variety of states and communities; national organizations; parents of children in the child welfare system, advocacy and family organizations; federal agencies; different cultural groups; research groups; and professional organizations.

The author is particularly grateful to other members of the project staff who committed their expertise and time, in the midst of multiple other responsibilities, to the successful implementation of this study.

Maria Woolverton, *Research Associate*
Girlyn Arganza, *Policy Associate*
Sara Schibanoff, *Research Assistant*
Chahira Kozma, *Developmental Pediatrician*
Donna Shelly, *Pediatric Clinical Nurse Specialist*

A special thanks goes to Suzanne Bronheim, Girlyn Arganza, and Maria Woolverton, of the Georgetown University Child Development Center, for their valuable critique of various drafts of this document and their candid suggestions for improvement. The design and formatting talent and expertise of Kylee Breedlove, and her patience with the many revisions, is also greatly appreciated.

Jan McCarthy
Project Director
Georgetown University Child Development Center



Table of Contents

<i>Acknowledgements</i>	iii
<i>Executive Summary</i>	vii
Chapter 1: Description of the Study	1
Health Care Needs of Children in the Foster Care System	1
Rationale for the Study	2
Purpose of the Study	2
Study Methodology	3
Rationale for the Selection of the Nine Sites to Visit	4
How This Document Is Organized	5
Publications Available from the Study	5
Chapter 2: Description of the Sample	7
Overview of the Sample	7
Types of Approaches in the Sample	8
Descriptions of the Nine Sites Visited	10
<i>Project for Adolescent and Child Evaluations</i>	10
<i>HealthWorks of Illinois and HealthWorks of Cook County</i>	10
<i>Foster Care Pediatrics</i>	11
<i>Child Health and Disability Prevention Foster Care Program</i>	11
<i>Assessment and Consultation Team</i>	12
<i>In-Care Network, Inc.</i>	13
<i>The Children's Aid Society Foster Care Clinics and</i>	13
<i>Mount Sinai Medical Center Collaboration</i>	
<i>Westchester Institute for Human Development Family Program</i>	14
Chapter 3: Overview of the Findings	15
Challenges	15
Meeting the Challenges	17
Benefits	18
Framework for a Comprehensive Approach: Critical Components	19
Interdependence of the Critical Components	22

Table of Contents

Chapter 4: Operationalizing the Framework for a Comprehensive Approach: Learnings from the Sites	23
Initial Screening and Comprehensive Health Assessment	23
Access to Health Care Services and Treatment	26
Management of Health Care Data and Information	28
Coordination of Care	30
Collaboration among Systems	31
Family Participation	33
Attention to Cultural Issues	36
Monitoring and Evaluation	37
Training and Education	38
Funding Strategies	40
Designing Managed Care to Fit the Needs of Children in the Child Welfare System	41
Additional Important Features and Characteristics	43
Continuing Challenges to Providing Comprehensive Health Care	43
Remaining Gaps in the Types of Approaches Offered	44
Chapter 5: Individual Site Examples	45
Initial Screening and Comprehensive Health Assessment	46
Access to Health Care Services and Treatment	47
Management of Health Care Data and Information	48
Coordination of Care	49
Collaboration among Systems	50
Family Participation	51
Attention to Cultural Issues	51
Monitoring and Evaluation	52
Training and Education	52
Funding Strategies	53
Designing Managed Care to Fit the Needs of Children in the Child Welfare System	54
Chapter 6: Summary of Advice and Recommendations	57
Major Recommendation	57
Recommendations for Each Component	58
Overarching Policy and Practice Recommendations	62
Analyzing and Addressing Service Gaps	63
Appendices	
Appendix A: Contact Information for Each Site Example	65
Appendix B: Compendium of Approaches Interviewed	67
Appendix C: Advisory Panel Members	71



Executive Summary

Chapter 1: Description of the Study

The Georgetown University Child Development Center recently completed a three-year study funded by the federal Maternal and Child Health Bureau, and supported in part by the Children’s Bureau, Administration for Children and Families, to identify and describe promising approaches for meeting the health care needs of children in the foster care system. Identification of these promising approaches is part of a larger effort of the *Public-Private Partnership for the Health of Children in Out-of-Home Care* (the Partnership) which also is supported by the Maternal and Child Health Bureau and the Administration for Children and Families. The goal of the Partnership is to improve and promote the health of children in foster care and their families.

Comprehensive health care refers to strategies and services for meeting the physical, dental, mental, emotional, and/or developmental health needs of children. It includes all health care—primary, tertiary, and specialty care.

Children in the foster care system refers to children who are in the custody of a county or state child welfare agency or a tribal court and who may live in a foster home, group home, kinship care home, residential treatment center, or other out-of-home placement. It includes children who will return home, as well as those for whom another permanent plan will be made.

The Partnership of federal agencies, national professional organizations, advocacy groups and family organizations, and state representatives acknowledged that:

- children in foster care have significant health problems;
- despite their greater needs and the availability of Medicaid for almost all children in foster care, numerous challenges prevent many children from receiving the care they need;

- once children enter state custody, the state becomes responsible for their health care;
- many states and communities are overcoming the challenges and implementing promising approaches for meeting the health care needs of children in the foster care system.

The Partnership recommended funding two studies. One study, led by the University of California at Los Angeles (UCLA) Center for Healthier Children, Families and Communities, conducted a national survey to assess factors affecting health service delivery to children in the foster care system. The purpose of the second study, initiated by the Georgetown University Child Development Center in 1999 and completed in 2001, was to identify and describe key features of promising approaches for delivering health care to children in state protective custody. This document is one of several prepared by the Georgetown University Child Development Center to describe the findings of the second study.

To locate promising approaches for delivering comprehensive health care to children in the foster care system, we conducted a very broad, yet targeted national search in 1999. As a result of the national search, 124 approaches representing 41 states were recommended. After contacting individuals at the 124 sites to request their participation in a telephone interview to collect more in-depth information, some approaches were screened out as not related to this study and several declined to participate. Using a written interview protocol, we conducted extensive telephone interviews in 1999-2000 with individuals from 73 recommended approaches in 35 states. To gather additional information from a wider array of stakeholders, we also selected nine sites to visit from May through December 2000. The following sites were selected for visits:

- **Project for Adolescent and Child Evaluations**, State of Arkansas
- **HealthWorks of Cook County**, Cook County, IL
- **HealthWorks of Illinois**, State of Illinois

- **Foster Care Pediatrics**, Monroe County, NY
- **Child Health and Disability Prevention (CHDP) Foster Care Program**, San Diego County, CA
- **Assessment and Consultation Team**, Riverside County, CA
- **In-Care Network**, Billings, MT
- **The Children's Aid Society**, New York, NY
- **Westchester Institute for Human Development Family Program**, Westchester County, NY

This document, *Meeting the Health Care Needs of Children in the Foster Care System—Summary of State and Community Efforts*, presents a discussion of the key findings of the study and describes important characteristics of strategies being implemented to improve the physical, emotional and developmental health of children in foster care. It is one in a set of reports resulting from the study. A companion document, *Strategies for Implementation*, provides readers with more detailed examples of the range of approaches states and communities are implementing and is designed to serve as a technical assistance tool for states and communities interested in developing a health care approach. Other publications available from the study, each entitled *Meeting the Health Care Needs of Children in the Foster Care System*, include the following:

- **Framework for a Comprehensive Approach—Critical Components**
- **Individual Site Visit Reports**
- **Fact Sheets Summarizing Specific Approaches**
- **Compendium of Approaches**
- **Topical Issue Briefs (in development)**
- **Literature Review (in development)**

All of the above products will be made available as they are completed on the Georgetown University Child Development Center's website at <http://gucdc.georgetown.edu/foster.html>. Printed versions also are available from Georgetown. See the website and cover page for ordering information.

Chapter 2: Description of the Sample

Overview

Most of the 73 approaches from 35 states that make up the sample for this study are serving all children in custody, rather than a subgroup of these children. The approaches are generally fully implemented and have been operational for several years. Some that are pilot projects expect to become statewide in the near future. The majority of approaches are being led by, or are housed in, public child welfare agencies or in public health agencies. About one-third of the approaches are collaborative efforts with more than one agency or system involved in a lead role. The approaches represent a mix of urban, suburban, and rural communities. Twenty are statewide approaches. Title XIX-Medicaid¹ and state funds are the most common funding sources supporting the approaches. The majority of approaches have not implemented national standards for the health care of children in foster care; however, several sites have created task forces to address strategies for meeting the health care needs of children in foster care. These task forces often use national standards such as the CWLA² and AAP³ Standards to guide their efforts.

Types of Approaches in the Sample

While the approaches in the sample are designed to fit the strengths and needs of the individual communities/states and the children and families served, they also can be categorized as representing one or more of 15 loosely structured “types” of approaches for enhancing the well-being and healthy development of children in foster care. The type of approach most commonly found in the study sample sites is *health care professionals working in the child welfare system*. Other types of approaches common to this sample of

sites include: *health data tracking, training, medical case management/care coordination, health screens and comprehensive assessments, and centralized health centers*.

Description of the Nine Sites Visited

Brief descriptions of the nine sites that were visited are provided in this chapter. Readers who are interested in more information about **individual** sites can obtain printed copies of detailed individual site visit reports from the Georgetown University Child Development Center. Copies also are available on the web in PDF format at <http://gucdc.georgetown.edu/foster.html>.

Chapter 3: Overview of the Findings

Challenges

Respondents described the many challenges and barriers to providing comprehensive health care for children in foster care. An overarching challenge is the extensive and complex health care needs of children in foster care and the lack of a comprehensive health care system to meet their needs. Challenges also fell within the child welfare system itself, within the health care system, and across systems. Challenges noted **within the child welfare system** include the frequency of placement changes that many children experience in foster care, lack of medical history information, the need for social workers and foster parents to have more knowledge about health care issues, and poor integration of health care plans and permanency plans. Challenges noted **within the health care system** relate to insufficient service capacity and a lack of qualified providers (especially mental health providers and dentists) who have experience with and are willing to serve children in the foster care

¹ Medicaid—Title XIX, a federal and state entitlement program to provide medical care coverage to persons with low-incomes, disabilities, blindness, the elderly, and families with children. States have the flexibility to define the services to be covered, but they must meet minimum federal requirements to be awarded matching federal funds.

² Child Welfare League of America. *Standards for Health Care Services for Children in Out-of-Home Care*. Washington, D.C.: CWLA, Inc., 1988.

³ American Academy of Pediatrics. “Health Care of Children in Foster Care.” *Pediatrics* 93 (1994): 335-338.

system. Low reimbursement rates for Medicaid providers contribute to the service capacity issue. Procedural issues such as delays in obtaining Medicaid coverage also are challenging. Respondents noted **cross-system challenges** that focused on issues related to communication between the health care and child welfare systems and the integration of physical health care and mental health care. Including families (birth, foster, adoptive, and kin) in the health care process and adapting health care services to meet the needs of children and families from diverse cultures also were noted as challenges.

Meeting the Challenges

Recognition of the challenges and barriers and the vision of leaders and advocates to correct the problems were the primary reasons cited by respondents for seeking solutions. Consent decrees also played an important role in several states. States and communities have pursued a number of different strategies for improving their systems for meeting the health care needs of children in foster care. Some focus on **front end care** by ensuring that children who enter foster care receive an initial health screen and a comprehensive health assessment. Some direct their attention to **children while they are in placement** by improving their ability to track health care data, ensuring better health care coordination, and broadening the service array and capacity through expanded health care provider networks or centralized health care centers. Others focus on **cross-system strategies** such as using the power of the court to focus attention on the health needs of children in foster care or conducting cross-system training on health care issues.

Benefits

Respondents linked the benefits of providing comprehensive health care directly to achievement of the three major goals of the child welfare system—*safety, permanency, and well-being*. They also noted the development of new services, enhanced collaborative relationships among child-serving systems, and cost effectiveness as benefits.

Framework for a Comprehensive Approach: Critical Components

The study determined that to fully attend to the complex physical health, mental health, and developmental needs of children in foster care requires the creation of a comprehensive, community-based health care system consisting of the following eleven **critical components**:

1. initial screening and comprehensive health assessment
2. access to health care services and treatment
3. management of health care data and information
4. coordination of care
5. collaboration among systems
6. family participation
7. attention to cultural issues
8. monitoring and evaluation
9. training and education
10. funding strategies
11. designing managed care to fit the needs of children in the child welfare system

The study defines these eleven components as a *Framework for a Comprehensive Approach*. A single organization, state or community in the study rarely addresses all eleven components. Recognizing this, we used the *Framework* as a guide in selecting the sites to visit so that, as a group, the nine sites provided information about promising approaches for each of the components in the *Framework*. An important finding from the study is that the critical components identified above are **interdependent**. Some sites found that focusing on one component in the *Framework* called attention to the need for work on other parts of their systems.

The *Framework* is presented as a finding of the study to provide a description of the kinds of issues to consider when designing a comprehensive approach to health care for children in foster care. It is not meant to be prescriptive, but rather to provide a range of ideas to discuss. We believe that consideration

of a comprehensive framework will help states and communities assess their systems, prioritize where to begin system change, and comprehensively address how to make improvements.

Chapter 4: Operationalizing the Framework for a Comprehensive Approach: Learnings from the Sites

Important Features and Characteristics

Using the *Framework for a Comprehensive Approach* that is described in Chapter 3, this chapter summarizes key features identified by respondents as important in implementing each of the 11 components of the framework.

■ Initial Screening and Comprehensive Health Assessment

- A system exists to identify and refer all children who enter foster care.
- Health history information is obtained from the child's family or caretaker.
- Screening and assessment sites are within a reasonable distance from a child's home and are open for extended hours.

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.

Both screenings and 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 screens 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.

- The screening process is set up to minimize trauma to the child.
- Screenings and assessments are based on accepted, consistent standards.
- To allow for immediate access to services, children are considered eligible for Medicaid when they enter care.
- An adult who knows the child well accompanies him/her to the comprehensive health assessment.
- A balance exists between conducting comprehensive health assessments that are too cursory and those that are too intensive.
- Qualified providers are available to conduct the assessments.
- A process exists to ensure follow-up on recommendations made in the assessment.
- In addition to assessing the individual child, assessments focus on other members of the child's family.
- Children receive assessments at regular intervals and when they move from one placement to another.
- Fiscal resources are adequate to sustain the screening and assessment system.

■ Access to Health Care Services and Treatment

- A protocol for emergency response is in place.
- Specific procedures for accessing both primary and specialty care are in place.
- Creative strategies are used to build a qualified provider network.
- Providers are community-based and located near where children and families live. (Some communities have established foster care clinics that specialize in health care services for children in foster care.)
- Community liaisons with knowledge of health care resources support the system.
- The approach carefully considers whether children in foster care should be enrolled in managed care.

- High level support (administrative and legislative) helps to fund, implement, and sustain the approach.

Access to Health Care Services and Treatment

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.

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.

Management of Health Care Data and Information

- Sites that use health passports consider the pros and cons of manual and electronic passports.
- Adequate clerical support is available to enter data in electronic passports.
- The health passport includes a child's medical history, immunization record, and a summary of ongoing care and test results.
- Providers are encouraged to complete the passport.
- Foster parents are encouraged to keep the health passport in a safe place and to pass it on to the child's next caretaker.
- Training in the use of the passport is provided for all involved persons.
- Some sites use standardized forms to record medical exams and other medical information.

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 ensures 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.

- Computerized management information systems support tracking and sharing information and identifying aggregate health care service needs.
- Health care information is used in service planning.

Coordination of Care

- One or more persons is assigned to provide health care case management for children in foster care.
- Public health nurses play an essential role in health care coordination and are often co-located at child welfare offices.
- Each child has a medical home.⁴
- The health care plan is incorporated in each child's permanency plan.
- A child's physical health care and behavioral health care are integrated.
- A process for systematic communication between the health care and child welfare systems is established.

⁴ A medical home is not a building or a place. It is a concept that implies that children will have a source (usually a single health care practitioner) for ongoing, comprehensive, coordinated, and continuous health care in their communities. This source of medical care is available for children even when they change placements, and will coordinate care for children with extraordinary needs. The American Academy of Pediatrics describes pediatricians and parents as partners in a medical home and recognizes the family as the principal caregiver and center of strength and support for children. (Adapted from American Academy of Pediatrics. "Policy Statement: The Medical Home." *Pediatrics* 90 (1992):774.)

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.

Collaboration Among Systems

- Strategies for communication (both formal and informal) between health and social service agencies are in place.
- Sharing office space among health care staff and child welfare staff provides an opportunity for ongoing communication.
- Interagency collaborative teams are used strategically, e.g., to conduct child and family assessments.
- Courts are included in the health care process.
- Involving community-based agencies helps to ensure continuity of care and access to services close to home.
- Collaborative leadership encourages all involved agencies to commit to the success of the approach.

Collaboration Among Systems

Health, mental health, child welfare, juvenile justice, courts, education, and other child-serving systems; providers; 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, advisory boards that are representative of the collaborators, formal interagency agreements, etc.

Family Participation

Two significant findings from this study related to family involvement are that:

- even when describing efforts to involve families, very few respondents considered these efforts to be “key features” or “strengths” of the approach;

- even though approximately 70% of children in foster care return to their birth parents or to relative care, many of the efforts to include families in planning for a child’s health care focused more on the foster parents than on the child’s birth parents or relatives.

Because family participation is not a strength of most sites, respondents described their challenges, as well as important features and characteristics. *Challenges* include:

- overcoming policies and practices that discourage or exclude birth parents from involvement in their child’s health care;
- securing funding that allows public health nurses to have direct contact with birth families and foster families. (The Medicaid funding codes used by a number of sites to support the involvement of public health nurses do not fund direct services.)

Important features that facilitate the involvement of families are described below.

- Birth families are invited to participate in the child’s initial screening (if possible), the comprehensive assessment, and in all health care visits.
- Families (birth, foster, relative, and adoptive) receive special individualized training in how to care for their children who have complex medical needs.
- Community-based clinics serve both children in foster care and their parents, thus

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.

reinforcing continuity of care when the children return home.

- In-home assessments in foster homes focus on the “fit” between the home and the child and identify additional supports needed.
- Families are involved at the system level in a variety of ways.

■ Attention to Cultural Issues

As in the component on family participation, a significant finding from this study is that with the exception of programs that serve a large number of children and families from a specific culture, respondents did not refer to their attempts to address cultural issues as key features or strengths of the approaches. However, some features which respondents noted as facilitating the delivery of culturally competent services are listed below.

- Community-based provider networks and clinics are located in neighborhoods where the children live.
- The site recruits culturally and linguistically diverse providers who reflect the population of children and families served.
- Written materials and health passports are available in a child/family’s primary language.
- Training on cultural competence is provided.
- Trained medical interpreters are used to assist during health care visits for children who speak little English and for children who are deaf.

■ Attention to Cultural Issues

A 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.

■ Monitoring and Evaluation

The majority of sites in this sample generally have not conducted objective, comprehensive program or outcome evaluations that could be used to determine the overall effectiveness of the approach or child health/mental health outcomes. However, they are engaged in **evaluation-related activities** such as those listed below.

- Many sites track adherence to procedural requirements such as the number of children who receive initial screens or comprehensive assessments on time.
- Several sites are tracking whether children receive the services recommended in their comprehensive assessments.
- Some sites are using quality assurance approaches at all levels of the system.
- Satisfaction surveys are frequently used to assess how the approach is working; however, while providers, foster parents, and social workers are surveyed, most sites do not ask birth parents about their satisfaction with the health care approach.
- Several sites evaluate their success by the achievement of each child’s individual goals.

■ 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.

■ Training and Education

- Training on health care issues for children in foster care occurs at all levels of the system.
- Hands-on, in-home training for families whose children have special medical needs is provided.
- Informal consultation occurs through co-location of health and child welfare staff, through multidisciplinary team meetings, and a variety of other mechanisms.

Training and 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.

- Rotations in foster care clinics provide a unique opportunity for medical and nursing students to learn about the special health care issues for children in foster care.

Funding Strategies

- Medicaid funds are used strategically to cover administrative costs, case management, and clinical services.
- State funds are used by some sites to cover administrative costs that are not reimbursed by Medicaid.
- Many approaches include funding from several different agencies.
- Fiscal incentives are used to encourage provider involvement and the provision of special services.

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 ensure 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.

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

- Special liaisons or special units in the public child welfare agency work closely with managed care organizations and assist families and social workers to navigate the managed care system.
- When children are placed in foster care, states that have an option to include or not include them in managed care assess carefully for each individual child whether managed care or a fee for service system is best.

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, the approach ensures that the special needs of children in custody 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 ensure 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.

Additional Cross-cutting Important Features and Characteristics

- Respondents from many sites describe nurses as a previously untapped resource for children and families in the child welfare system.
- Respondents noted the importance of creating the right management structure to implement and sustain the health care approach.
- Positive relationships across and within systems are crucial.
- Strong leadership and commitment to a common vision is essential.

- Flexibility and responsiveness are necessary traits for those in leadership positions and for the approach itself.
- Respondents noted that even with sustained implementation of the approach, they continue to experience many challenges.

Chapter 5: Individual Site Examples

This chapter offers the reader illustrations from individual sites that describe how they are implementing the critical components of the *Framework for a Comprehensive Approach*. One to three examples are provided for each of the 11 components. To request further information from the sites themselves, contact information is provided in Appendix A.

Chapter 6: Summary of Advice and Recommendations

Major Recommendation

The challenge is to strengthen service capacity and to create a comprehensive health care system for children in foster care that integrates health and social services for each child and family. States and communities that face this challenge would benefit from using the *Framework for a Comprehensive Approach* described in Chapter 3 to begin a dialogue about what needs to be accomplished and how to begin to move forward. In this process, it is also helpful to review more detailed information and practice parameters such as standards developed by the Child Welfare League of America and the American Academy of Pediatrics (mentioned previously in this document).

Recommendations for Each Component

The *Framework for a Comprehensive Approach* is used to sort, understand and analyze the many recommendations and advice offered by respondents. This section of Chapter 6 provides a summary of specific recommendations offered by respondents for each of the eleven components.

Overarching Policy and Practice Recommendations

- Create a **system** to actualize the recommendations and strategies. A system implies having the organizational **structure** in place, the **resources** available, and a **process** to implement the strategy.
- Implement improvements in health care services in **all phases** of a child/family's involvement with the child welfare system. This includes: before entering care, at the point of entry, during the time a child is in care, at transition points, and after leaving foster care.
- Build partnerships among local, state, and federal governments to enhance health care services and outcomes for children in foster care. Examine and clarify roles related to: committing to the vision, providing or creating the resources, reducing barriers in existing policies, developing new policy, creating incentives, and implementing the changes.

Analyzing and Addressing Service Gaps

Issues that are important to providing comprehensive health care for children in foster care, but that represent ongoing challenges for, or are missing from, most of the 73 approaches that are part of this study's sample include:

- providing appropriate health care services for adolescents;
- strengthening participation by birth families and kinship care providers;
- providing mental health services for children with mild to moderate mental health needs;
- providing dental care;
- meeting a child's health care needs at transition points;
- focusing on appropriate health care services for children of color.

It is not possible to conclude from this study that these issues are not being addressed in other states, communities, and individual programs that are not part of the study sample. However, it is essential for states and communities that are undertaking an effort to better meet the health care needs of children in foster care to consider including these issues in their planning efforts.

CHAPTER 1

Description of the Study

Discussed in this Chapter

- Health care needs of children in the foster care system
- Rationale and purpose for this study
- Study methodology
- Rationale for selecting the nine sites to visit
- How this document is organized
- Publications available from the study

Health Care Needs of Children in the Foster Care System

Children come to the attention of the child welfare system for many different reasons. Many have experienced abuse or neglect, and someone has determined that they need protection. In other families, parents have turned to the child welfare system as a last resort to gain access to extensive mental health services for their children that they have not been able to get through other child-serving systems. Children in both of these groups tend to be extremely vulnerable. Like all children they need well-child care, immunizations, and treatment for acute illnesses. However, they also require even greater attention due to their high risk for health, mental health and developmental problems.

Results of studies profiling the health status of children in foster care demonstrate that they have significantly higher rates of acute and chronic medical problems, developmental delays, educational disorders and behavioral health problems than other children of similar backgrounds.¹ Various studies have found that 80% of children in foster care have at least one chronic medical condition, 25% have three or more chronic problems^{2,3} and an estimated 30%-70% of children in foster care have severe emotional problems.⁴ The trauma of separation from their families and the frequent experience of multiple placements within the foster care system itself often compound these conditions.

Many studies of the well-being of children in foster care have been limited to children in specific localities or states. However, in January 2002, the Urban Institute published a **national** overview of the well-being of children in the child welfare system.

¹ Simms, M.D., and Neal Halfon. "The Health Care Needs of Children in Foster Care: A Research Agenda." *Child Welfare* 73 (1998): 505-524.

² Silver, Judith et al. "Starting Young: Improving the Health and Developmental Outcomes of Infants and Toddlers in the Child Welfare System." *Child Welfare* 78 (1999): 148-165.

³ Halfon, Neal et al. "Health Status of Children in Foster Care." *Archives of Pediatric and Adolescent Medicine* 149 (1995): 386-392.

⁴ Child Welfare League of America. *Standards for Health Care Services for Children in Out-of-Home Care*. Washington, D.C.: CWLA, Inc., 1988: 1-3.

Using data from the 1997 and 1999 National Survey of America's Families, they found that when compared with all children living with biological, adoptive, or stepparents, children in foster care had higher levels of behavioral and emotional problems, were more likely to be suspended or expelled from school, had lower levels of engagement in school, and more frequently had a limiting physical, learning, or mental health condition. The Urban Institute study also found that children in the child welfare system were receiving more services for their needs, or at least were not receiving fewer services, than the general population of children.⁵

While states and communities generally acknowledge first and foremost the importance of offering services and supports that families need in order to care for their children in their own homes, when children do enter foster care, states assume many parental powers. With these powers comes the responsibility to ensure the well-being of the children and to help their families develop the capacity to meet their needs. States have both the responsibility and the opportunity to provide comprehensive health care for each child in foster care.

Rationale for the Study

In 1995, the Maternal and Child Health Bureau (MCHB) along with the Administration for Children and Families (ACF), both of the U.S. Department of Health and Human Services, came together to explore how to support each others efforts to enhance the health and well-being of America's children. Their efforts resulted in a group known as the MCHB-ACF Technical Advisory Group (TAG). A subcommittee of the TAG convened a separate group, the *Public-Private Partnership for the Health of Children in Out-of-Home Care* (the Partnership), which committed to collaborating on efforts to improve access to health care for children in state protective custody. This Partnership of

federal agencies, national professional organizations, advocacy groups and family organizations, and state representatives acknowledged that:

- children in foster care have significant health problems;
- despite their greater needs and the availability of Medicaid for almost all children in foster care, numerous challenges prevent many children from receiving the care they need;
- once children enter state custody, the state becomes responsible for their health care;
- many states and communities are overcoming the challenges and implementing creative strategies (promising approaches) for meeting the health care needs of children in the foster care system.

The Partnership committed to taking a holistic, family-focused approach encompassing the health of families (foster, biological, and kinship), in order to improve the well-being of children in foster care and their families. They developed five recommendations to further these efforts.

Purpose of the Study

The first two recommendations resulted in funding for two studies. One study, led by the University of California at Los Angeles (UCLA), Center for Healthier Children, Families, and Communities, conducted a national survey to assess factors affecting health service delivery to children in the foster care system. The purpose of the second study, initiated by the Georgetown University Child Development Center in 1999 and completed in 2001, was to identify promising approaches for delivering health care to children in state protective custody by:

- locating and examining promising approaches being undertaken by states, communities, and individual programs throughout the country;

⁵ Kortenkamp, K. and Ehrle, J. *The Well-being of Children Involved with the Child Welfare System: A National Overview*. New Federalism National Survey of America's Families. Series B, 8-43. Washington, D.C.: The Urban Institute, 2002.

- determining from among these sites key features and characteristics that contribute to ensuring effective health care services for children in the foster care system;
- publicizing the findings.

Both studies were funded by the federal Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services. The Georgetown study was also supported, in part, by the Children’s Bureau, Administration for Children and Families, Department of Health and Human Services. We are reporting in this document the findings of the study conducted by the Georgetown University Child Development Center.

Study Methodology

To locate promising approaches for delivering comprehensive health care to children in the foster care system, we conducted a very broad, yet targeted national search in 1999. States, communities, and individual programs voluntarily nominated themselves or were nominated by others who believed they were doing promising work. It was not a goal of the study to locate potential approaches in every state, nor to locate **all** promising strategies in the country. However, the pool of recommended approaches turned out to be very comprehensive, and 41 states were represented. The greatest number of nominations came from New York and California.

A recruitment flier to solicit nominations suggested that recommended approaches include some, but not necessarily all, of the following characteristics:

- assures adequate health care for each child in foster care;
- meets each child’s immediate, short-term, and long-term needs;
- tracks health care received in all placements;
- involves multiple stakeholders;

⁶ See Appendix B for a list of sites that were interviewed. Fact Sheets are available for many of these approaches from the Georgetown University Child Development Center and on its website <http://gucdc.georgetown.edu/foster.html>.

Comprehensive health care refers to strategies and services for meeting the physical, dental, mental, emotional, and/or developmental health needs of children. It includes all health care—primary, tertiary, and specialty care.

Children in the foster care system refers to children who are in the custody of a county or state child welfare agency or a tribal court and who may live in a foster home, group home, kinship care home, residential treatment center, or other out-of-home placement. It includes children who will return home, as well as those for whom another permanent plan will be made.

- builds on family strengths;
- has innovative organizational, service delivery, or financial arrangements;
- promotes child safety, permanence and well-being;
- delivers culturally and linguistically competent services and supports;
- has written policies about health care standards;
- meets specific standards set by state or community;
- could be replicated in other states and communities.

Following the national search, we contacted the 124 nominated sites to request their participation in a telephone interview to collect more in-depth information. A few sites were screened out as not related to this study. A written interview protocol was constructed, and in 1999 and 2000, we conducted extensive telephone interviews with individuals from 73 sites in 35 states. To gather additional information from a wider array of stakeholders, we also selected nine sites to visit (see further discussion below).

While study findings are based primarily on the 73 nominated approaches that were willing to participate in an extensive telephone

interview and/or site visit,⁶ we continued to learn about promising approaches even after completion of all telephone interviews and site visits. Some of these additional approaches have been added to our data base and will be referenced in narrative sections of this report. Numerous other states, communities, and programs, not included in this study, also offer promising strategies for meeting the health care needs of children in the foster care system.

An advisory panel worked closely with project staff throughout the project. The panel's wisdom was essential in identifying potential approaches, defining the focus of the study, analyzing the data and information that was collected, recommending sites to visit, conceptualizing the comprehensive framework described in Chapter 3 of this document, identifying emerging themes, and recommending strategies for presenting and disseminating study findings. Panel members represented the child welfare, health care, mental health, and juvenile justice fields; a variety of states and communities; national organizations; advocacy and family organizations; federal agencies; different cultural groups; and professional organizations.

Rationale for Selection of the Nine Sites to Visit

The Study recognized that 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 critical components (see sidebar—described fully in Chapter 3). Based on data from the telephone interviews, the project advisory committee and staff realized that no single site was likely to demonstrate competence in all of these critical components. We therefore selected nine sites that together as a group, would provide information about promising approaches for addressing each of the critical components. We also chose a group of sites that represented a

range of geographic locations (urban, suburban, rural), lead agency types, service areas (city, county, statewide), and populations served. The group of sites included approaches that offered physical health, mental health, and developmental services.

The following sites were selected for visits:

- **Project for Adolescent and Child Evaluation**, State of Arkansas
- **HealthWorks of Cook County**, Cook County, IL
- **HealthWorks of Illinois**, State of Illinois
- **Foster Care Pediatrics**, Monroe County, NY
- **Child Health and Disability Prevention (CHDP) Foster Care Program**, San Diego County, CA
- **Assessment and Consultation Team**, Riverside County, CA
- **In-Care Network**, Billings, MT
- **The Children's Aid Society**, New York, NY
- **Westchester Institute for Human Development Family Program**, Westchester County, NY

Visits to obtain in-depth information about each site took place between May and December 2000. Key stakeholders—including

Framework for a Comprehensive Approach: Critical Components

- initial screening and comprehensive health assessment
- access to health care services and treatment
- management of health care data and information
- coordination of care
- collaboration among systems
- family participation
- attention to cultural issues
- monitoring and evaluation
- training and education
- funding strategies
- designing managed care to fit the needs of children in the child welfare system

child welfare administrators and caseworkers, health and mental health agency administrators and direct service providers, birth parents and foster parents, court staff and CASA representatives, and health care providers from other organizations such as hospitals and clinics—were interviewed during the site visits. Chapter 2 provides brief descriptions of the approaches used in each of these nine sites.

How this Document is Organized

Meeting the Health Care Needs of Children in the Foster Care System—Summary of State and Community Efforts presents a summary and discussion of the key findings from the state and community efforts that were studied. It describes important characteristics of strategies being implemented to improve the physical, emotional and developmental health of children in foster care. This document is one in a set of reports resulting from the study. A companion document, *Strategies for Implementation*, provides readers with more detailed examples of the range of approaches states and communities are implementing and is designed to serve as a technical assistance tool for states and communities interested in developing a health care approach.

Summary of State and Community Efforts is organized as follows:

- **Chapter 1: Description of the Study**—discusses the health care needs of children in foster care and the rationale and purpose for studying promising approaches for meeting these needs. It explains the study methodology, identifies how this document is organized, and presents available project publications.
- **Chapter 2: Description of the Sample**—summarizes information related to all of the approaches in the sample—the populations served, types of agencies leading the approach, locations, funding sources, types of standards used to develop the approach, and their implementation status. It demonstrates how the approaches in the sample can be categorized into certain “types”. The chapter also presents a brief description of each of the nine sites that were visited during the study.
- **Chapter 3: Overview of the Findings**—presents a summary of the challenges to providing comprehensive health care, why and how some states and communities are meeting these challenges, and the benefits of doing so. The chapter also describes a framework for developing a comprehensive approach to health care for children in foster care. This framework, which includes 11 components, evolved from the findings of this study and from work done by other organizations to create standards for care.
- **Chapter 4: Operationalizing the Framework for a Comprehensive Approach**—Learnings from the Sites—using each component of the comprehensive approach described in Chapter 3 as the framework, this chapter summarizes features and characteristics identified by respondents as important in implementing many of these components. It also discusses continuing challenges and identifies gaps in the types of approaches being offered by this study’s sample.
- **Chapter 5: Individual Site Examples**—provides brief, practical examples of how states, communities, and individual programs are implementing each of the 11 critical components of the comprehensive framework.
- **Chapter 6: Summary of Advice and Recommendations**—summarizes the advice offered by the sites, that were interviewed or visited, for other states and communities trying to strengthen health care services for children in foster care. This chapter concludes with policy and practice recommendations based on the findings of the study.

Publications Available from the Study

We are developing a number of different types of publications to assist states and communities in their efforts to improve health care services for children in the foster care system. These products, each entitled *Meeting the Health Care Needs of Children in the Foster Care System*, include the following:

- **Framework for a Comprehensive Approach**—Critical Components: Definitions of 11 critical components to address in planning a comprehensive system of health care for children in the foster care system.
- Two companion documents:
 - **Summary of State and Community Efforts:** Summary and discussion of key findings from both the site visits and telephone interviews.
 - **Strategies for Implementation:** Technical assistance tool that describes individual site examples and identifies considerations for states and communities interested in developing strategies for addressing the health care needs of children in foster care.

Together these two companion documents provide a complete picture of the study findings and how the findings can be used to strengthen the health care system for children in foster care.

- **Individual Site Visit Reports:** Comprehensive reports that provide details about the strategies used in each of the nine sites that we visited.
- **Fact Sheets:** Brief (1-3 page) summaries of many of the approaches interviewed by telephone or on site. Contact information is included on each fact sheet.
- **Compendium of Approaches:** State-by-state listing with contact information for the various approaches identified in the study
- **Topical Issue Briefs (in development):** Discussions of some of the most interesting findings and themes of the study, designed to provide more detailed and targeted information about topics highlighted in the *Summary of State and Community Efforts and in Strategies for Implementation*.
- **Literature Review (in development):** Summary of the literature on the health and mental health issues affecting children and families in the foster care system

All of the above products will be made available as they are completed on the Georgetown University Child Development Center's website at <http://gucdc.georgetown.edu/foster.html>. Printed versions also are available from Georgetown. See the website for ordering information.

CHAPTER 2

Description of the Sample

Discussed in this Chapter

- Descriptive information related to all of the approaches in the sample
- Summary of the types of approaches in the sample
- Brief descriptions of the nine sites that were visited

Overview of the Sample

To provide an overview of the total sample, in this chapter we have aggregated information on each of the 73 approaches in 35 states that make up the sample for this study. Topics addressed below include: the population of children being served, which agencies are taking the lead in the approaches, how extensive a geographic area is covered by each approach, funding sources being used, national standards that influenced the design of the approaches, and implementation status.

Target Population

Most of the programs (50) are intended to serve all children in custody, rather than a subgroup of these children. Ten approaches targeted a special subgroup characterized as children with special health care needs.⁷

Lead Agencies

The majority of approaches are being led by or are housed in public child welfare agencies (42) or in public health agencies (18). Other agencies taking a lead role in these approaches included: hospitals (14), universities (11), non profit organizations (10), and private child welfare agencies (9). It is interesting to note that about one-third of the approaches (28) that were studied were collaborative efforts with more than one “lead agency” involved in developing and implementing the approach.

Geographic Area

The majority of approaches interviewed served one or more counties (41), while fewer were statewide approaches (20). Eight approaches served specific cities. The approaches represented a mix of urban, suburban, and rural communities.

⁷ Children with special health care needs have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition requiring health and related services of a type or amount beyond those required by children generally (*Achieving Success for All Children and Youth with Special Health Care Needs-A 10-Year Plan*, Foreword from the Surgeon General, 2001).

Funding Sources

The funding source most used to support the approaches was Title XIX-Medicaid⁸ (39). State funds were the second most used funding source (31). Local funds supported 17 approaches, and grants or research funds were involved in financing 16 approaches. Federal funds that are targeted specifically for the child welfare system such as Title IV-B and Title IV-E were used very infrequently to support the health care approach.^{9,10} Approaches also used “other” funding sources such as private contributions, United Way, Department of Labor, private foundations, endowment funds, Bureau of Indian Affairs, Indian Health Services, tribal funds, Federal Court Improvement Projects, mental health system of care grants, victim witness programs, and university medical centers.

Using National Standards

One of the issues probed in this study was the extent to which promising approaches used existing national standards for the health care of children in foster care (e.g., Child Welfare League of America and American Academy of Pediatrics).^{11,12} We found that several sites had created task forces that were charged with making recommendations about better ways to meet the health care needs of children in foster care. These task forces often used the AAP and CWLA Standards to guide their efforts (e.g., California, Utah, and New York). The AAP and CWLA guidelines also were influential in the development of HealthWorks, a comprehensive statewide approach implemented in Illinois in 1993. In approaches that were offering direct care services for children, respondents also described strategies for ensuring that health care providers meet specified standards, including the use of Early

and Periodic Screening Diagnosis and Treatment (EPSDT) standards and guidelines for health screens and health exams.

Implementation Status

The approaches nominated for this study are generally “fully implemented” (54). Only one program identified itself as “in the planning stages”, and nine were “partially implemented”. However, even those that are fully implemented expressed the intention to expand, to make modifications, and to evolve as needs changed. A number of the programs were pilot projects that were expected to become statewide in the near future.

Types of Approaches in the Sample

The states and communities studied represent a wide variety of approaches for enhancing the well-being and healthy development of children in foster care. These approaches have been designed to fit the strengths and needs of each individual community and the children and families it serves. After completing the telephone interviews and before site visits were conducted, we characterized the approaches under one or more loosely structured “type”.

The types of approaches presented here are not mutually exclusive. Some sites implemented several types within a broad approach while others focused their efforts on a single type of approach. The type of approach found to be most commonly used among this sample was *health care professionals in child welfare* (39). Health care professionals have begun to fill a number of critical roles in the child welfare system. Other types of approaches being implemented in a significant number of states

⁸ Medicaid—Title XIX, a federal and state entitlement program to provide medical care coverage to persons with low-incomes, disabilities, blindness, the elderly, and families with children. States have the flexibility to define the services to be covered, but they must meet minimum federal requirements to be awarded matching federal funds.

⁹ Title IV-B of the Social Security Act—authorizes state public child welfare agencies to use federal funds for child and family services. These funds may be used for families and children without regard to their income.

¹⁰ Title IV-E of the Social Security Act—authorizes states to provide foster care, independent living, and adoption assistance programs for children who would have been eligible for AFDC, if still in their own homes.

¹¹ Child Welfare League of America.

¹² American Academy of Pediatrics. “Health Care of Children in Foster Care.” *Pediatrics* 93 (1994): 335-338.

TYPES OF APPROACHES TO PROVIDING HEALTH CARE	
TYPE	DEFINITION
Health Care Professionals in Child Welfare	Health care professionals (often public health nurses located in the child welfare agency) provide a variety of services for children, families, and child welfare staff. E.g., care coordination, referrals, training, monitoring/evaluation and direct treatment.
Health Data Tracking	Health care information is obtained and tracked for each child in custody. The health “passport” is one example of this type of approach.
Training/Education	Training, education, and/or consultation about health care for children in foster care is provided for health care professionals, child welfare staff, birth and foster parents, court personnel, and others.
Medical Case Management/Care Coordination	Individual health care case management or care coordination is provided, often using public health nurses in this role or contracting with private agencies to coordinate health care.
Formalized Health Screening and Health Assessments	Formalized procedures to ensure that all children entering care receive health screenings and comprehensive health assessments.
Centralized Health Center	A central location for children in custody to obtain medical care, usually offering initial screenings, comprehensive assessments, primary care, some specialty care, and referral to other specialists. Usually located in a hospital, within a larger health center or clinic, within a non-profit social services agency, or linked to a university medical center. Includes centers that provide mental health and developmental assessments. Some centers provide care for family members of children in custody, others do not.
Enhanced Behavioral Health Assessment and Services	Focused on serving children with severe behavioral or emotional problems. Often includes mental health screening and assessment upon entry into care, consultation on mental health issues, referral to a specialty network of providers, or placement with specially trained foster parents.
Specialized Services for Children Who Are Medically Fragile	Assures appropriate care for children with very complex medical needs in the least restrictive environment. Uses highly skilled foster parents, 24-hour supports, and care coordination. Children are linked to specialty services and clinics.
Private Child Welfare Agencies Offering Health Services	Agencies that have expanded beyond placement services to provide health care services and/or medical case management for children placed with the private agency, and often for other children in foster care. Usually a clinic setting.
Centralized Resource Coordination	A centralized resource center that offers information about health care, locating providers, special services, and advocacy
Professional Foster Parents	Specially trained foster parents offer therapeutic foster care for children with serious emotional disorders or serious medical conditions. Reimbursement often based on level of care provided and foster parent’s level of skills/training.
Addressing Managed Care Issues	Two aspects: <ul style="list-style-type: none"> • using managed care technology to provide medical services for children in foster care • special strategies for navigating managed care in order to access services
Ensuring Developmental Services for Young Children	Meeting the needs of very young children through assessments, use of multidisciplinary teams, coordination with IDEA Early Intervention Services, and providing developmental services.
Reunification and Permanency Planning	Identifying health issues that might stand in the way of a child having a permanent home. Involving birth families in child’s health care. Offering services after reunification. Meeting the health needs of other family members.
Other	Examples are: mobile crisis unit; center for adolescent health; statewide task force.

and communities include: health data tracking (31), training (25), medical case management/care coordination (23), health screens and comprehensive assessments (21), and centralized health centers (18).

Descriptions of the Nine Sites Visited

Brief descriptions of the sites that were visited are provided below. Readers who are interested in more information about **individual** sites can obtain printed copies of detailed individual site visit reports from the Georgetown University Child Development Center. Copies also are available on the web at <http://gucdc.georgetown.edu/foster.html> in PDF format.

1 Project for Adolescent and Child Evaluations *State of Arkansas*

Objectives

- To provide multidisciplinary, comprehensive health evaluations for all children entering foster care
- To ensure that follow-up services, based on recommendations from the comprehensive evaluation are received

The Project for Adolescent and Child Evaluation (PACE) is a collaborative effort between the Division of Children and Family Services Arkansas Department of Human Services (DCFS) and the University of Arkansas for Medical Sciences Department of Pediatrics (UAMS). PACE provides multidisciplinary team evaluations for all children in foster care in Arkansas within 60 days of entering state protective custody. PACE uses roving assessment teams consisting of pediatricians, psychologists, psychological examiners, speech/language pathologists, and others, as needed, to conduct comprehensive health assessments in 16 sites located around the state. In the year 2000, PACE completed comprehensive evaluations of 1,953 children. In the year 2001, 2,043 evaluations were completed.

PACE tracks whether needed follow-up services based on recommendations from the comprehensive health and developmental evaluations are received. At county-level offices, DCFS has approximately 20 health service workers who 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.

Funding Sources

Administration of the PACE project is funded by a contract between UAMS and DCFS. Medicaid reimbursement funds clinical services. ♦

2 HealthWorks of Illinois

*State of Illinois** and

3 HealthWorks of Cook County

*Cook County, Illinois**

Objective

- To ensure accessible, essential, well-coordinated, continuous, comprehensive, quality health care services for children in the care and custody of DCFS

HealthWorks is a health care system implemented in Illinois by the Department of Children and Family Services (DCFS) in collaboration with the Department of Public Aid and the Department of Human Services which uses a community-based approach to serve all 31,000 children in custody except for those who are living in a detention facility or in an inpatient psychiatric hospital. Approximately 70-75% of the children in custody in Illinois live in the Chicago area (Cook County).

HealthWorks has several key program features:

- an Initial Health Screening prior to or within 24 hours of a child's entry into DCFS custody;
- a Comprehensive Health Evaluation within 21 days;

*The site visit reports for HealthWorks of Cook County and HealthWorks of Illinois are combined as one report.

- a primary care physician enrolled in the HealthWorks provider network for each child;
- regular well-child examinations and immunizations;
- access to ongoing coordinated comprehensive health care, including access to specialized health care;
- medical case management for children under age six;
- documentation of health needs and receipt of health care through a Health Passport and standardized medical records.

Funding Sources

HealthWorks is funded primarily through Medicaid. State general revenue funds from the Illinois Department of Children and Family Services are used for costs not reimbursed by Medicaid, including lead agency administrative services. The Illinois Department of Human Services funds the monitoring activities of Maternal and Child Health nurse consultants. ♦

4 Foster Care Pediatrics

Monroe County, New York

Objectives

To provide:

- comprehensive, high quality, primary health care for children in foster care;
- coordination of health care services;
- support and education for foster families and casework staff;
- advocacy;
- development of collaborative efforts to enhance wellness.

Foster Care Pediatrics is a full service primary care pediatric clinic dedicated to providing comprehensive medical services to children in foster care in Monroe County, NY. Foster Care Pediatrics operates under the auspices of the Monroe County Department of Health in collaboration with Monroe County Department of Social Services. The program serves approximately 90% of the children who

live in foster family care in the county and averages 4,000 visits per year.

The clinic provides primary care services on site, bimonthly developmental screenings conducted by a developmental pediatrician, on-site assessment of sexual and physical abuse situations, and careful monitoring of children receiving psychotropic medications.

Comprehensive developmental, mental health, and other consultations are obtained from the community and tertiary care centers. Foster Care Pediatrics provides nights and weekend coverage through contracts with a group of nurses who provide triage services and assistance to families.

Funding Sources

Foster Care Pediatrics is funded through Medicaid reimbursement, with additional financial support from the Monroe County Department of Health. ♦

5 Child Health and Disability Prevention (CHDP) Foster Care Program

San Diego County, California

Objectives

For children in foster care:

- to increase access to and utilization of preventative health care resources;
- to increase documentation of health status and existing health problems;
- to increase the number of children who receive needed medical treatment for health problems.

The Child Health and Disability Prevention (CHDP) Foster Care Program was established in 1989 as a joint project between the Department of Health Services and the Department of Social Services, Children's Services Bureau in San Diego County. Four Public Health Nurses (PHNs), operating via an interagency agreement, are housed in the Children's Services Bureau offices. The PHNs work in a collaborative, interdisciplinary manner with social workers to address the

health care needs of children in foster care. Approximately 7,100 children were in care in July 2000.

The PHNs who are co-located with child welfare staff provide the following services:

- on-site technical assistance and training for social workers;
- training and consultation on health issues to foster families;
- linking children to medical and dental care;
- follow up on health problems identified during routine exams;
- nursing expertise in multidisciplinary case consultations;
- coordination of the Health and Education Passport program;
- nursing assessment and synthesis of medical, educational, and psychological information for the Health and Education Passport;
- liaison to health care providers serving children in foster care;
- state leadership on health issues related to children in foster care.

Funding Sources

The primary funding source for the CHDP Foster Care Program is Medi-Cal (Title XIX-Medicaid), supplemented by a local match. Social Services provides funding to hire the clerical staff for the health passport and provides office space for the public health nurses and clerical staff. Shortly after the site visit, to support the role of public health nurses in the child welfare system, general state funds were made available by the state legislature for all county child welfare agencies to match with federal Medicaid dollars. This enables San Diego County to hire 13 additional nurses for the CHDP Foster Care Program. ♦

6 Assessment and Consultation Team *Riverside County, California*

Objectives

- To provide child and families served by the Department of Public Social Services DPSS

with access to an expanded range of mental health assessment and treatment services

- To monitor the quality and quantity of mental health services provided
- To reduce local expenditures by billing Medi-Cal (California's Medicaid program) whenever possible.

The Assessment and Consultation Team (ACT) was created through an interagency agreement between the Department of Mental Health (DMH) and the Department of Public Social Services (DPSS) in Riverside County, CA. Licensed mental health clinicians from DMH are located in DPSS offices throughout the county to initiate the process of obtaining coordinated mental health services for children receiving child welfare services. They are involved with approximately 3,000 children at any point in time. This includes children in foster care and children living in their own homes who receive services from DPSS.

The ACT clinicians are responsible for:

- providing consultation to DPSS social workers regarding mental health issues related to the children served by DPSS;
- direct clinical assessment of children served by DPSS whose clinical needs are unclear;
- determination of treatment to be provided through county operated mental health clinics or to be authorized through the Department of Mental Health managed care plan;
- initial referral/authorization for mental health services;
- routine review of mental health treatment plans and requests for extension of services.

Additionally, all children ages 3-18, who live in shelter care homes (initial placements when removed from their own homes) receive clinical assessments within thirty days.

Funding Sources

Funding for the ACT approach is provided through Medi-Cal (Title XIX-Medicaid) and by the Riverside County Department of Public Social Services. ♦

7 In-Care Network, Inc.

Billings, Montana

Objectives

In-Care's mission is:

- “Every Indian child is unique and sacred. Each of our children must be empowered and given the opportunity to enrich his/her own life.” In-Care is dedicated to the well being of the Indian child, which is achieved and maintained through the balance of the mind, body and spirit.

The In-Care Network, Inc. is a Montana based, non-profit (501-C-3) corporation that provides therapeutic foster care services for Indian youth. It is a licensed child placement agency founded to meet the needs of American Indian youth who have serious health or mental health conditions. In-Care is committed to establishing and maintaining high quality social services and educational programs. The agency serves 60-70 youth and draws from a resource of 90-100 therapeutic foster homes. Two-thirds of the foster parents are American Indian, and the majority of staff are also Indian. Some youth are referred by the state of Montana social service agency; however, the majority are referred by tribes in Montana, with a few out-of-state referrals.

It is In-Care's belief that the unmet needs of the Indian child can be healed and treated through a holistic approach to human services and that the entire Indian community must take ownership of the process and be involved in the development of solutions to the problems that plague Indian children and families.

The In-Care Network provides the following therapeutic foster care services:

- Coordination of In-Care services to the Indian youth;
- In-Care support services to the foster families, including Respite Care;
- Counseling and other supportive services to the natural and extended families;
- Comprehensive case management services;

- Cooperation with the referring child placement agency in permanency planning;
- Support groups for Indian youth (Vision Seekers and Grandchild Journey);
- Transitional living program for youth ages 16-21;
- Services for expectant mothers or teen parents;
- 24-hour on call service.

Funding Sources

A number of different funding sources have responsibility to pay for services offered by In-Care including: Title IV-E funds, Medicaid, state funds, Bureau of Indian Affairs, tribal funds, and Indian Health Services. The organization also receives some funding from grants and foundations. ♦

8 The Children's Aid Society

Foster Care Clinics and Mount Sinai Medical Center Collaboration

New York, New York

Objective

- To improve the health status of children in foster care through a collaboration between the Children's Aid Society and the Mount Sinai Medical Center

The Children's Aid Society has been in existence for 130 years as a private, non-sectarian social welfare agency serving New York City. The agency's foster care program serves approximately 700 children in private foster homes. In addition to its foster care program, the agency provides programs for recreation and community services, and operates school-based clinics and foster care clinics through its health division.

Children in foster care receive primary care services at the Children's Aid Society's Midtown Manhattan clinic (co-located in the same building as the agency's social work staff) and community-based clinics in Harlem and the South Bronx. These clinics offer on-site medical, dental, and mental health services.

Pediatric nurse practitioners (PNPs) on staff provide many direct services as well as health care management for children in foster care.

Through its collaboration with Mount Sinai Medical Center, pediatricians from Mount Sinai are placed in the foster care medical clinics. The collaboration also provides easy access to the many specialty pediatric clinics available at Mount Sinai Hospital. At each site, in addition to health services, The Children's Aid Society provides social services, recreational, family support and educational support programming.

The Children's Aid Society manages two unique foster care programs—Medical Foster Boarding Homes for children with chronic and multiple medical conditions, and Therapeutic Foster Boarding Homes for children with behavioral or emotional problems. These programs allow children to be cared for in the homes of foster parents instead of being institutionalized. A nurse and a social worker partner to manage the health and case planning needs of these children.

Funding Sources

The Children's Aid Society receives a medical per diem rate for each child placed by New York City's Administration for Children's Services. The medical per diem covers the cost of services offered at the Children's Aid Society foster care clinic. Services provided at Mount Sinai are billed directly to Medicaid by the hospital. ♦

9 Westchester Institute for Human Development (WIHD) Family Program *Westchester County, New York*

Objective

The goals of the Family Program at WIHD are to enhance permanency for children in foster care by:

- identifying health, developmental and mental health needs of children entering family foster care;
- providing services to address their unmet health, developmental and mental health needs;

- preventing re-placements (moving from one foster home to another);
- preventing more restrictive placements;
- facilitating the development of permanency plans.

WIHD is a University Center for Excellence in Developmental Disabilities Education, Research and Service. WIHD is a part of the Westchester Medical Center, and is affiliated with New York Medical College in Valhalla, NY. As a University Center for Excellence, WIHD's mission is to enhance the quality of life of individuals with or at-risk for disabilities, and their families.

The Family Program is a collaborative effort between the WIHD and the Westchester County Department of Social Services designed to meet the child welfare permanency goals by providing developmental and mental health services to all children in family foster care in the county, their birth parents, and their foster families. Approximately 850 children are in foster care at any point in time in Westchester County.

The Family Program offers many services for children and families in the foster care system, including:

- assessment of each foster home placement (in-home assessment) shortly after placement to determine the "fit" between the foster home environment and the child, and to identify needed services and supports;
- comprehensive developmental assessment of each child and a functional assessment of each child's birth parents, including an assessment of parent-child interaction;
- training and support for foster families;
- developmental and mental health intervention services for children and their parents.

Funding Sources

Family Program services are funded through contracts with the Department of Social Services and through Medicaid billing. ♦

Overview of the Findings

Discussed in this Chapter

For children in foster care and their families:

- challenges to providing comprehensive health care
- why and how states and communities are meeting the challenges
- benefits of providing comprehensive health care
- critical components of a comprehensive framework for meeting their health care needs

Challenges

In the study, we probed for information about challenges and barriers, common across sites, that had to be overcome as new and promising approaches were being developed to meet the health care needs of children in foster care. Respondents also described many general system-wide challenges, in addition to challenges to implementing specific approaches. General cross-system challenges, challenges within the child welfare system, and challenges within the health care system noted by respondents are discussed in this chapter.

General Challenges

General challenges relate to the vulnerability of children in foster care and the lack of a comprehensive health care system to meet their needs:

- the intensive and multi-layered health, mental health and developmental needs of the children (as described in Chapter 1);
- the compounding of these needs by placement of children in out-of-home care, and by multiple replacements that frequently occur;
- thus, the lack of a continuous relationship with a caring adult who can observe their development, advocate on their behalf, and consent to services;¹³
- the lack of a comprehensive system or structure designed specifically to address health care needs of children in placement

Challenges within the Child Welfare System

Many child welfare agencies face system problems that, while much broader than health care issues, affect their ability to provide comprehensive health care for children in foster care:

- specific child welfare system problems, e.g., high caseloads, limited resources, frequently changing social workers, attorneys, and foster parents;

¹³Dicker, Sheryl, Elysa Gordon and Jane Knitzer. *Improving the Odds for the Healthy Development of Young Children in Foster Care*. Promoting the Emotional Well-being of Children and Families. New York City: National Center for Children in Poverty, 2001.

- confusion about who is responsible to consent to a child’s evaluation and treatment and difficulty in obtaining consent;
- poor integration of health care plans and permanency plans, e.g., a reluctance to make health care and health plans a priority; permanency and safety often seen as separate and more critical than health and well-being;
- inconsistent levels of knowledge about health care issues among social workers and caregivers in the child welfare system;
- lack of information about the child’s and family’s health history and inadequate strategies for gathering this information from parents or other caretakers at the time of placement when immediate safety issues take precedence;
- inadequate efforts to include birth parents in the health care of their children, e.g., no consistent policy about involving birth parents, decisions left to individual worker discretion, limited direct contact between birth parents and health care providers;
- lack of transition supports and continuous care when child returns home.

Challenges within the Health Care System

Publicly funded health care systems face challenges that impact many children and families. These challenges are frequently compounded for children in foster care because they need access to providers who understand and can meet their unique health care needs. Challenges include:

- insufficient service capacity and access to care, e.g., a lack of qualified providers to serve children and families on Medicaid, and very few dentists accepting Medicaid;
- insufficient attention to and services for children with mild to moderate mental health needs;
- need for more qualified mental health providers;
- low reimbursement rates for Medicaid providers;
- delays in obtaining Medicaid coverage;
- inappropriate health care for children and families from diverse cultures, e.g., too few providers representing the culture of the families and children served; assessment instruments that are normed only on children from the majority culture; lack of translation of medical reports into the family’s primary language; and lack of qualified interpreters.

Health care systems also traditionally are administered separately from child welfare systems and do not have ready access to information about how the child welfare system works. Challenges noted by respondents include:

- lack of understanding and attention to the unique needs of children in foster care;
- insufficient knowledge about how the child welfare and judicial systems work;
- confusion about the roles of foster and birth parents, the role of the court in ordering and monitoring health care services, and consent issues;
- managed care programs that are not designed to accommodate the needs of children in foster care.

Cross-system Challenges

Creating a comprehensive system for meeting the health care needs of children in foster care requires multiple systems to work together. Respondents noted cross-system challenges in working with the courts, managed care organizations, mental health, child welfare, and the health care system, including:

- integrating physical health and mental health care;
- clarifying among systems roles and responsibilities for mental health service provision;
- strengthening communication between health care providers and child welfare workers;
- getting courts to discuss child and family health needs during court proceedings;

- complicated management information systems and the inability to “talk” across systems;
- confidentiality issues about access to data;
- inflexible funding sources;
- lack of consistent cross-system training and education to teach child welfare staff about health care issues and to teach health care professionals about the child welfare system.

Meeting the Challenges

Why States Have Chosen to Search for Solutions

Awareness of the challenges and barriers identified above has prompted many states and communities to develop solutions. The recognition of inadequate care and the vision of leaders and advocates to correct the problem were the primary reasons cited by respondents for seeking solutions. Consent decrees also played an important role in several states. The study identified the following catalysts that led to the development of new approaches:

- recognition of the unmet health needs and disjointed services for children in foster care;
- recommendations from city, county, or statewide task forces on health care for children in foster care;
- consent decree requirements that came about due to inadequate health care for children in foster care;
- attempts to make the most of managed care mandates;
- rising costs of health care;
- the desire to initiate and control an appropriate health care system for children in foster care;
- the vision of leaders and advocates.

How the Challenges Are Being Met

Prompted by such catalysts, states and communities have pursued a number of different strategies for meeting the health care needs of children in foster care. Some focus on

front end care and services through such strategies as:

- a formalized system to assure that each child who enters care will receive an initial screening and also receive a complete comprehensive health assessment;
- systems for assessing the developmental needs of young children and the mental health needs of all children in care.

Some approaches focus attention on coordinating health care **during the time children are in the foster care system.**

For example:

- development of health data tracking systems such as health passports and centralized data bases;
- care coordination and medical case management, often provided by nurses;
- housing nurses, mental health clinicians, and consultants in child welfare offices;
- expansion of the services offered by private child welfare placement agencies to include direct provision of primary health care by establishing health clinics;
- creation of centralized health care centers to serve most of the children in foster care in that community.

Other respondents described strategies for **expanding and strengthening health care provider networks**, including:

- development of community-based provider networks;
- endorsement and implementation of comprehensive health care standards;
- securing providers of specialized services for children with very complex needs.

Cross-system strategies included using the power of the court to focus attention on the health needs of children in foster care and to ensure that services are received. A number of sites train parents and other caregivers, providers, and social workers in health care issues, and also do cross-system training.

Benefits

The benefits of providing, coordinating, and tracking health care services for children in foster care were described by many respondents in this study. Some of the benefits discussed are directly linked to the three major goals of the child welfare system—**safety, permanency, and well-being**.

Safety

Respondents linked health care and a child's healthy development to achievement of the goal of safety, i.e., protecting the child from abuse and neglect (including medical neglect). To ensure a child's safety and avoid life-threatening situations, parents, caregivers, agencies and providers must have a clear understanding of a child's health care needs, as well as the services and supports required to meet those needs. As both parents and child welfare staff become more knowledgeable about health care issues, and as health care providers become more aware of the circumstances surrounding the lives of children in foster care, they all become more effective in dealing with children's health, mental health, and developmental needs and more aware of what supports must be in place to ensure their safety.

Permanency

The child welfare system is charged with helping children secure a permanent home. Providing appropriate health care can help reduce the stress that often disrupts stable placements. Respondents described strategies for including health plans in six-month administrative reviews, in court hearings, and in decision-making related to finding and maintaining the right permanent home for a child. Having adequate information about a child's health assists parents, agencies and courts in making recommendations for appropriate placement. When children and their families receive the care they need, the

child's placement (temporary or permanent) is more likely to be successful. Whether the goal is reunification with their families or another permanent plan such as adoption or legal guardianship, children benefit from appropriate health care services, and parents benefit from education and support services related to their children's care.

Well-being

Each child's well-being, i.e., his/her physical health, mental health, developmental, and educational needs, must be addressed while in foster care. The child welfare system is also charged with enhancing a parent's capacity to provide for his/her child's needs. Early and comprehensive care enhances a child's chance for healthy development, provides supports for caregivers,¹⁴ and can reverse bleak prognoses, strengthen families and enhance permanency.¹⁵

Service Development

While few sites were analyzing aggregate data about the health care needs of children in foster care, some respondents noted the benefits of having this information to identify system-wide service needs and gaps, and to promote the development of new services. In many of the approaches that were studied, health care providers became more experienced in working with children in foster care, thus expanding the network of qualified providers.

Enhanced Collaborative Relationships

Respondents acknowledged the benefit of different systems working together to meet the health care needs of children in foster care and felt that such cross-system collaboration contributed to helping separate systems become focused on the same goals for children and families. Co-location of staff from one agency (e.g., mental health) in another agency (e.g., child welfare) provided benefits for both systems and for children and families.

¹⁴ Dicker, Sheryl and Elysa Gordon. "Connecting Healthy Development and Permanency: A Pivotal Role for Child Welfare Professionals." *Permanency Planning Today* 1 (2000): p. 13.

¹⁵ New York State Permanent Judicial Commission on Justice for Children. *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals*. White Plains, NY: Permanent Judicial Commission on Justice for Children, 1999.

Cost Effectiveness

Respondents acknowledged the value of providing health care services early and comprehensively rather than providing intensive services later in a time of crisis.

Framework for a Comprehensive Approach: Critical Components

As stated earlier, 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. As we studied approaches that states and communities are using to provide health care for children in foster care, it became clear that many components of a comprehensive system are being implemented. In order to frame the findings of this study, we captured these components and defined them as a Framework for a *Comprehensive Approach: Critical Components*. The list of “critical components” presented here reflect:

- learnings from 73 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 America¹⁶ and the American Academy of Pediatrics;^{17,18}
- values embraced by systems of care that serve children with special mental health needs;¹⁹
- the wisdom of the advisory group that assisted in analyzing the findings of this project.

In the study, a single organization, state or community rarely addressed all of the components. Recognizing this, we used the

Framework for a Comprehensive Approach: Critical Components

- initial screening and comprehensive health assessment
- access to health care services and treatment
- management of health care data and information
- coordination of care
- collaboration among systems
- family participation
- attention to cultural issues
- monitoring and evaluation
- training and education
- funding strategies
- designing managed care to fit the needs of children in the child welfare system

framework as a guide in selecting the nine sites to visit so that, as a group, the nine sites provided information about promising approaches for each of the components in the framework (see Chapter 2 for additional information).

Definitions of the critical components are presented here to provide states and communities with a description of the kinds of issues to consider when designing a comprehensive approach to health care for children in foster care. Although policy development is not listed as a separate component within the framework, its importance was evident in our interviews and implementation of these components is dependent upon strong child welfare and cross-system policies.

Many of the approaches that we studied address one or more of the first four components in the framework as the basis for a major initiative to improve health care services for children in foster care. However,

¹⁶ Child Welfare League of America.

¹⁷ American Academy of Pediatrics, 335-338.

¹⁸ American Academy of Pediatrics. Committee on Early Childhood and Adoption and Dependent Care. “*Developmental Issues for Young Children in Foster care.*” *Pediatrics* 106 (2000): 1145-1150.

¹⁹ Stroul, Beth and Robert Friedman. *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, (1994): p. 18.

fewer sites focused on the last seven components which we consider to be cross-cutting, i.e., they can be addressed in some way as part of any approach that is implemented.

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.

■ 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.

Both screenings and 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 screens 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.

■ 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.

■ 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 ensures 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.

■ 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.

■ 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, advisory boards that are representative of the collaborators, formal interagency agreements, etc.

■ 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 ensure 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.

■ Attention to Cultural Issues

A 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.

■ 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.

■ 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.

■ 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 ensure 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.

■ 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, the approach ensures that the special needs of children in custody 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 ensure 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.

Interdependence of the Critical Components

One important finding from the study is that the critical components identified above are **interdependent**. Many promising approaches we studied were developed for a **specific** purpose or to address a particular problem or need. For example, some had focused on providing comprehensive assessments for every

child in foster care. Others had implemented health passports so that they would have complete medical information on each child. Still others addressed the issue of coordination of care and access to follow-up services, often through the involvement of public health nurses. While a more targeted focus enabled sites to create strong and distinctive approaches, some sites found that focusing on one component in the framework called attention to the need for work on other parts of their systems. For example:

- Sites that created systems for conducting comprehensive assessments on all children discovered that they needed to have a care coordination process in place to ensure follow-up on the recommendations made in the assessment. They also needed an adequate provider capacity to provide the recommended services.
- Sites that developed health passports, but that did not focus on family involvement, found it difficult to gather child and family medical history information that should be included in the passport. Similarly, sites that implemented health passports learned that training for social workers, caregivers, and providers was essential to get them to use the passports.

CHAPTER 4

Operationalizing the Framework for a Comprehensive Approach

Learnings from the Sites

Discussed in this Chapter

- Features and characteristics described as important for implementing each component of the comprehensive framework
- Additional features that cross all components
- Continuing challenges to providing comprehensive health care
- Gaps in the types of approaches being offered

Components of a Comprehensive Approach

- initial screening and comprehensive health assessment
- access to health care services and treatment
- management of health care data and information
- coordination of care
- collaboration among systems
- family participation
- attention to cultural issues
- monitoring and evaluation
- training and education
- funding strategies
- designing managed care to fit the needs of children in the child welfare system

Using the framework for a comprehensive approach that is described in Chapter 3, this chapter summarizes features and characteristics identified by respondents as important in implementing many of the approaches that were studied. The information is organized by the 11 components of the comprehensive framework. To review examples of how individual sites demonstrate the features and characteristics described in each component in this chapter, see Chapter 5.

■ 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.

Both screenings and 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 screens 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.

During the course of the study (telephone interviews and site visits), we talked with 29 sites about their approaches to conducting initial screening and/or comprehensive health assessments. The majority of these 29 sites offered initial health screenings, comprehensive physical health assessments, and comprehensive mental health assessments. Developmental assessments were offered less frequently (19 sites), and dental assessments were conducted in eleven of the sites interviewed.

*Initial Screening and Comprehensive Health Assessment Continued***Important Features and Characteristics**

Sites differ in their approaches to conducting initial health screens and comprehensive assessments in several ways, e.g., determining which children to include, who conducts the screenings and assessments, when and where they occur, what they cover, and how they are funded. Despite these differences, a number of features were identified across sites as contributing to implementation of the approach. These features are discussed below in three groups: as they relate to **both** initial screens and assessments, to initial screening, and then to comprehensive assessments.

Features Related to Both Initial Screening and Assessments

- **Create a *system* to identify and refer all children.** To successfully provide initial health screenings at the time a child enters foster care, a system has the capability to identify every child at the time of entry and to assign the responsibility for transporting each child for a screening. The screening becomes a standard procedure for every child who enters foster care and is not left to individual caseworker discretion. The approach also has a system to refer children for comprehensive assessments and to track when, and if, they receive assessments within a defined period of time.
- **Obtain health history information.** The approach has addressed the issue of collecting health history information from the child's family or caretaker. Some sites have assigned this task to nurses who meet with birth families in court at the custody hearing or who visit them at home.
- **Make screening and assessment sites accessible.** Sites are within a reasonable distance from the child's home and are open for extended hours. This is especially important for initial health screenings that occur prior to placement. Sites being used include: hospital emergency rooms, multiple sites located around the state and staffed by

roving teams, central receiving/health centers, contract agencies, specified provider networks, and assessments in the foster home.

- **Commit adequate fiscal resources.** Some sites initiated special/higher Medicaid reimbursement rates for the initial health screens and for comprehensive assessments. Contracts to support the management of the assessment process were funded to adequately cover administrative costs. Because Medicaid will not pay for "no shows", in one state, the contractor charges the Division of Children and Family Services when assessment appointments are missed. This has created a strong incentive and reduced the number of missed appointments.

Features Related to Initial Screening

- **Minimize the trauma to the child.** Children who enter foster care are in the midst of trauma. Screening personnel and sites are sensitive to the child's condition and make the screening process as quick and as comfortable as possible.
- **Presume that each child is eligible for Medicaid.** Assuming that every child who enters foster care will be eligible for Medicaid allows for immediate health care services. There is no wait to determine Medicaid eligibility. Sites that do this indicate that almost all children later become officially eligible.

Features Related to Comprehensive Health Assessments

- **Involve an informed adult participant.** It is important that the child is accompanied to the comprehensive assessment by someone who knows him/her well, is able to provide needed information, and can assist the child through any difficulties. This may not be possible at an initial screen, but it is essential during the full assessment. Some sites require foster parents to accompany the child. One or two sites involved birth parents in the comprehensive assessment process.

- **Determine how comprehensive assessments should be.** Comprehensive health assessments address multiple domains of a child’s life, including medical, emotional, behavioral, and developmental issues. When comprehensive assessments are done universally (for every child entering care), it is important to determine that the provider(s) conducts a thorough examination and that assessments do not become perfunctory or cursory. It is also important that the assessment not be overly intensive or traumatic for the child. When conducting assessments on all children entering care, respondents identified the need to strike a balance between assessments that are too cursory and those that are too intensive. Factors in this decision are how the information is used, costs, and the importance of individualizing the assessment process for each child.
- **Use consistent standards.** Assessments are based on accepted, consistent standards, e.g., EPSDT screening standards.
- **Use qualified providers to conduct assessments.** Providers are familiar with the foster care system and are qualified by experience, knowledge and skill to serve this population of children. They reflect the various cultures represented by the children and families. Some sites use strong established community-based organizations to conduct the assessments. Pediatricians and nurse practitioners play important roles in the assessment process. Multidisciplinary teams are also used to provide comprehensive assessments.
- **Monitor follow-up on recommendations.** Recommendations from the comprehensive assessment are sent to the appropriate persons, and a formal process exists to monitor whether follow-up occurs. In several sites a child’s individual health plan was created to guide follow-up care. Others used a centralized random monitoring system.

- **Recognize the value of comprehensive assessments.** There was general consensus that the comprehensive assessment process often confirmed suspicions and provided valuable information to help everyone (family, caregivers, schools, judges, social services, providers) understand the child better and to meet health care needs more appropriately.

Additional Considerations

The following additional features were discussed by respondents as important for the success of a strong screening and comprehensive assessment program; however, they were less evident in many approaches and not evident at all in some of the approaches.

- **Focus on the child’s family and environment.** This includes an assessment of the strengths and needs of other members of the child’s birth family. This was evident in two of the nine sites visited.
- **Assessments should be ongoing.** Children need to be re-assessed at regular intervals and when they move from one placement to another. This includes children who are reunifying with their parents, children who later return to foster care, youth who leave foster care to live independently, and children who move into other permanent placements such as adoption. Most of the sites that were conducting comprehensive assessments focused primarily on assessment shortly after a child enters care. Very few created a system for ongoing assessments or assessments at transition points in a child’s life. ♦

■ 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.

From site visits and telephone interviews, more than 20 sites described their approaches for increasing a child's **access to health care services**. Twenty-two of the sites interviewed described employing health care consultants to assist child welfare staff; 17 depicted their efforts to develop an adequate provider network; and 11 had health care providers working on site at the child welfare agency.

Some of the sites interviewed provided **direct health care services**. Approximately 20 sites described their approaches to offering primary care, mental health care, services for children with special health care needs, and developmental services. Fewer sites offered emergency care and dental health care.

From among the sites that were offering **direct services**, the study found several different approaches for providing care:

- **Two types of foster care clinics were described:**
 - *Clinics based at large private child welfare provider agencies* that have been created to

serve the children placed with the private agency. These clinics are usually found in large urban areas where the public child welfare agency contracts with private agencies for foster care placements.

- *Centralized clinics* that are developed specifically to serve all (or, at least, most) of the children in foster care in a specific county or city. These clinics, as well as the clinics run by private child welfare agencies, often have ties to medical centers, university hospitals, or large children's hospitals in order to access specialty care.
- **Community-based clinics** that specialize in serving children in foster care, but also serve other children and families. Such clinics are available to families after reunification with their children and are usually located in neighborhoods where the children and families live.
- **Special networks** of individual, community-based health care providers created to serve foster children. Providers in these networks must meet certain qualifications and participate in activities related to foster care, e.g., filling in health passports (if applicable) and using standard health forms.
- **Individual providers chosen by the foster family.** In some sites, foster families select providers that they know and use. The providers may or may not have previous experience in working with children from the child welfare system. This is the most loosely structured method of accessing care with the least amount of control by the child welfare agency.

Important Features and Characteristics

Even though sites focused on different strategies for accessing and providing health care, they identified several common features that were important to implementation. Some of these features focus on access issues, some are more pertinent to service delivery, and others are applicable to both. A number of features

important to access and services were also cited by respondents as key to implementing systems for screening and assessment.

Features Related to Both Access and Service Delivery

- **Establish a system for obtaining health care.** The system defines specific procedures for access to a primary care physician, regular well-child exams, up to date immunizations, access to specialty care providers, and consultation with medical experts (e.g., public health nurses) when needed. Such a system supports individual caseworkers and foster parents in their efforts to help a child access care, rather than leaving them to figure this out child by child.
- **Commit high level support to the approach.** Support from the highest levels (administrative and legislative) helps to fund, implement, and sustain a comprehensive approach to services and treatment. For example, the Illinois Department of Children and Family Services established an Office of Health Policy to manage HealthWorks. This Office reports directly to the Commissioner. The California legislature passed a law to fund and co-locate public health nurses in child welfare offices.
- **Recruit and retain qualified providers.** Strategies respondents described to find appropriate providers and build provider networks include:
 - influence and persuasion by agency administrators, other providers, and foster parents;
 - reduced paperwork demands;
 - minimal prior authorization requirements;
 - enhanced reimbursement rates;
 - increased support and oversight.

Some approaches have established qualifications for providers such as:

 - specialization in caring for children;
 - board certification;
 - hospital admitting privileges;
 - 24-hour coverage;
 - participation in Medicaid and meeting basic EPSDT exam standards;

- use of standardized medical forms;
- agreement to complete health passports.

- **Offer a central location for accessing services.** Respondents from the sites that operated foster care clinics stressed the value of locating all services for children in foster care under one roof in a centralized location (sometimes at a social service agency or a university medical center). This provides access to multiple services and to providers with extensive expertise in the unique health care issues of children in foster care and their families. Clinics usually are based where a critical mass of children and families live. However, some respondents from these sites pointed out the inconvenience for families who do not live nearby, lack of choice in providers, and the stigma associated with centralized clinics that serve primarily children in foster care.

Features Related to Increasing Access

- **Establish a protocol for emergency response.** Families have access to 24-hour telephone lines and staff/providers on call.
- **Locate providers in the community.** Providers are community-based and located near where the children and families live. In Cook County, IL, the lead agency clusters providers by zip code to enable foster families to find a nearby provider.
- **Build knowledge of community resources.** Community liaisons, who know how to develop and find needed resources (e.g., a public health nurse or a mental health clinician), facilitate access to appropriate services. It is helpful for these liaisons to be located in the child welfare agency.
- **Find the best health plan for children in foster care.** The study found that in several sites, children in the custody of the child welfare agency were automatically disenrolled from the Medicaid managed care system when they entered foster care.²⁰ In some other sites, the agency had the option to disenroll them. When optional, considerations centered around access to

Access to Health Care Services and Treatment Continued

specific providers and a level of care that might not have been available under managed care. When children were disenrolled, the health care providers billed Medicaid directly under a fee for service arrangement. While this was useful for obtaining services during a child's placement, it often meant a change in providers, and possibly in eligibility for services, when the child moved home on to another permanent placement.

Features Related to Services and Treatment

- **Establish direct access to specialty care.**

Primary care providers (PCPs) are able to refer children directly to specialists without prior authorization or approval. In Illinois, primary care physicians can make referrals directly to specialists who are not required to be enrolled as HealthWorks providers.

However, the specialists must return findings and recommendations to the PCP who is a network provider. Centralized clinics, such as Foster Care Pediatrics in Monroe County, NY, have collaborative relationships with teaching hospitals and private specialists in the community that facilitate access to specialty care.

Additional Considerations

A consistent finding from both telephone interviews and site visits was the difficulty that sites experience in accessing dental care for children in foster care and appropriate mental health services. The barrier most often noted to these services is a lack of providers willing to accept Medicaid and to serve this group of children. ♦

²⁰This finding differs from the findings of the Health Care Reform Tracking Project, a national study which addressed, in part, the impact of managed care on children in the child welfare system who need behavioral health services. The Tracking Project found in an all-state survey that 82% of the 35 publicly funded managed care plans in the study included children in the child welfare system. SOURCE: Stroul, Beth, Sheila Pires and Mary Armstrong. *Health care reform tracking project: Tracking state health reforms as they affect children and adolescents with behavioral health disorders and their families—2000 State Survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. 2001.

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 ensures 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.

The study found that sites were gathering, using, and sharing health information about foster children in a variety of ways. Forty-four sites discussed strategies they use to collect, review and retain medical records for each child. Many approaches described access to electronic medical records (24) and the use of a health passport (23).

Important Features and Characteristics

Respondents described features important to the implementation of health care passports, standardized health forms, computerized management information systems, and processes for using health care information in service planning.

Consider what type of health passport would be most useful.

Sites described using both manual and electronic health passports. Manually completed health passports are the most common approach. Some sites also record educational information in the passport. Although less common than the manual passport, several sites felt that a computerized passport ensured a central location for the passport information and that it was less likely to be lost than a paper passport.

Obtain health history information for the health passport.

Establish strategies for gathering child and family health history information at the time of placement to include in the passport.

Provide incentives to participate in the health passport process.

- **Incentives for Providers**

Fiscal incentives, training and support help ensure completion by providers.

- **Incentives for Foster Parents**

Support and encourage foster parents to participate. Passports should be extensive enough to include useful information, but not so long and complicated that they will not be completed and used. Invite foster parents to provide feedback on how to improve the passport. Active involvement of foster parents is crucial in implementing health passports, especially manual versions. They usually are responsible for taking the passport to providers at the time of appointments and asking them to fill it in. They are responsible for ensuring that the passport is not lost and that it is passed on to the child's next caretaker.

Ensure adequate clerical support for electronic passports.

Adequate support from trained clerical staff is essential for entering data in electronic passports.

Guarantee that the passport accompanies the child.

Respondents stressed the importance of

Health Passport—a personal health record for each child in foster care that includes available health information such as medical history obtained when the child enters care, demographic information, immunization record, a listing and brief summary of each visit to a medical provider while in foster care, lab and test results, growth information, insurance information, and other special health, mental health, and developmental information. Some passports include information about a child's placement history.

The health passport is intended to provide information to everyone involved with the child and to ensure that important health information accompanies the child when s/he leaves foster care.

providing a copy of the passport to each new caretaker for a child, and especially for birth parents or other permanent caregivers at the time a child leaves foster care. Teenagers who age out of the foster care system also need to have a completed passport.

Use standardized health forms.

Some sites have created standard forms for providers to use when recording the results of a child's health exam in order to ensure that children receive health care according to EPSDT standards and to provide a permanent and uniform central health record for each child. Data from these forms is often entered into a central information system.

Easily accessed computerized management information systems serve a variety of purposes.

- as a central health care record for each child;
- to track medical, dental, and mental health services for each child;
- to identify when medical appointments are to occur;
- to share information on line about a child's health care needs among social workers, health care coordinators, and providers;
- to identify emerging health issues for children in foster care, service gaps and

Management of Health Care Data and Information Continued

resource needs which help in making policy and practice decisions.

Create a process to ensure that health care information is used in service planning.

Health care summaries on individual children are discussed in biannual administrative case reviews to assist in service planning.

Commit resources to aggregating health care data.

While few sites were doing this, several

stressed the value of aggregating data collected on individual children in foster care to determine answers to questions such as:

- do children with specific diagnoses remain in foster care longer or experience more placements;
- what are the emerging health issues for children in foster care;
- what resources are needed to meet their needs. ♦

■ 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.

In the early stages of this study, as telephone interview protocols were being developed, we did not specifically ask whether coordination of a child's health care was assigned to a specific person or to a unit of persons. However, we learned, over the course of the study, how important coordination of care is in many approaches and how sites are accomplishing this. One of the most significant findings of the study was the extent to which nurses are involved with the child welfare system, especially in the role of care coordinators and developing health care plans for children.

Important Features and Characteristics

A number of features were identified by respondents as contributing to effective care coordination.

Create a strategy for providing health care case management.

This is a critically important function in

coordinating health care. Case managers gather, compile, and update health information; track and ensure access to care; and contribute health care information during case reviews. Respondents indicated that an approach must allocate sufficient time and resources, and identify one or more persons to provide health care case management, or it will not occur.

Assess how public health nurses can play a role in care coordination.

Nurses are an essential element in many of the approaches we studied. They fill a variety of important roles that are discussed later in this chapter under "additional features". Their role as care coordinators is one of the most significant.

Ensure that each child has a medical home.

Because each child in foster care needs a "medical home" to provide a source of ongoing, comprehensive, coordinated, and continuous health care in his/her community, several sites focused on this. Foster care clinics and community-based primary care physicians serve as medical homes. Because a child in foster care often experiences several different placements, it is even more important (and more difficult) to ensure that s/he has a medical home.

Develop a health care plan for every child in care.

Health care plans which identify a child's needs and how those needs will be met are a vital part of care. Respondents described the importance of incorporating the health care plan in the child's permanency plan and addressing health care and health status in all case reviews and court hearings.

Integrate each child's physical and behavioral health care.

The child welfare system is concerned about

each child's well-being which includes both physical and emotional health. Respondents described the importance of coordinating the physical and mental health care a child receives.

Establish systematic communication processes.

Several sites described the importance of specified liaisons from the child welfare system who know and understand health care issues to bridge the gap between health care providers and child welfare agencies. ♦

■ Collaboration Among Systems

Health, mental health, child welfare, juvenile justice, courts, education, and other child-serving systems; providers; 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, advisory boards that are representative of the collaborators, formal interagency agreements, etc.

A wide variety of agencies, organizations and groups were involved in the approaches in this study's sample. They included: child welfare, Medicaid, health (e.g., public health, nurses, hospitals, pediatricians, community-based health care providers, Indian Health Service), mental health, early intervention services/system, courts, probation, Court Appointed Special Advocates (CASA), schools, community organizations and resources (e.g., recreation programs, camps, community houses, housing authorities, visiting nurses association), tribal organizations, family and advocacy organizations, parents (birth, foster, and adoptive), hospitals, and universities.

Important Features and Characteristics

Characteristics noted by respondents in many sites as facilitating cross-system collaboration are described below.

Develop a variety of strategies for consistent communication.

Collaboration and communication between health and social services is critically important. Respondents described frequent informal communication, as well as more formal communication strategies such as regular meetings of interagency task forces, planning groups, and oversight bodies. Memoranda of understanding and formal contracts often specify how regular communication is to occur. Designated liaisons between agencies were described as another means of strengthening and clarifying communication. Respondents noted that collaboration among agencies around one issue, e.g., the approach for improving health care for children in foster care, strengthens relationships in other areas as well.

Share office space.

Respondents repeatedly stressed the value of locating health care staff and child welfare staff in the same office. Co-location provides an opportunity for ongoing consultation, interaction, information sharing and shared

Collaboration Among Systems Continued

problem solving. Staff of different agencies, with different perspectives, become part of the same team—colleagues working toward the same goals. Each system begins to understand the realities and constraints, as well as the strengths, of the other system. Child welfare staff learn about health and mental health issues. Health care staff learn how the child welfare system works and the unique health needs of children and families in the system. Respondents noted that historic tension between systems does not dissipate completely, but is eased considerably when staff work with the same children and families and in the same office.

Use interagency collaborative teams strategically.

Many approaches described the use of multidisciplinary teams in conducting child and family assessments and developing health plans for children. They also identified interagency teams that are involved in planning, implementing, and problem solving. Clinics that focused on serving children in foster care included staff from several disciplines and are places that social workers, families, and medical staff can come together both formally and informally.

Include the courts in the health care process.

Respondents described two different approaches for working with courts. One approach is to provide health care information about individual children so that judges can make informed decisions based on a full knowledge of the child's situation. In some sites, public health nurses testify in court or write letters to explain a child's condition to the judge. Mental health clinicians provide information to judges about the purpose and effect of specific medications that children were taking.

Another approach is to harness the influence of the courts to enhance the healthy

development of children in foster care. In New York, the Permanent Judicial Commission on Justice for Children has focused attention on the health and development needs of children in foster care through a multi-pronged initiative to assist courts in identifying the health needs of all children in foster care, to improve the delivery of services to these children, to highlight the connection between healthy development and permanency, and to use the authority of the court to order needed services.²¹ (See site example in Chapter 5.)

Work with community-based agencies.

Working with community-based agencies is one way to ensure continuity of care and services close to home. As children return to the community, they need to be able to access services in their own communities. In Illinois, the lead agency for HealthWorks in Cook County is made up of 100 community-based agencies. This facilitates finding health care providers near foster homes and birth family homes. Outside of the Chicago area (downstate), local community-based health departments serve as the lead agencies. Health departments were selected to be lead agencies, in part, because they are based in the community, know the providers, were already doing family case management, and their philosophy emphasizes preventative care.

Decide which agencies will provide leadership for the approach.

There were divergent responses to this issue. Most respondents stress that the approach must be an equal collaboration among the involved agencies. They indicated that collaborative leadership of the approach encourages all involved agencies to make a commitment to its success. A few respondents, while acknowledging the value of collaboration, felt that the child welfare agency should remain in charge and “own” the program in order to assure accountability and to achieve results quickly. ♦

²¹ Dicker, Sheryl and Elysa Gordon. “Harnessing the Hidden Influence of the Courts to Enhance the Healthy Development of Foster Children.” Protecting Children, a publication of American Humane Association.

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 ensure 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.

Children in the child welfare system may be included in several “families”. They may live with, or be working toward reunification with, their birth parents. They may live with extended family members who serve as their guardians, often called kinship care. They may live with foster families, and those who cannot return to their birth families, frequently are adopted. To ensure family participation means listening to, involving and addressing the needs of all of these families.

Two significant findings from this study related to family involvement are that:

- even when describing efforts to involve families, very few respondents considered these efforts to be “key features” or “strengths” of the approach
- even though approximately 70% of children in foster care return to their birth parents or to relative care, many of the efforts to include families in planning for a child’s health care focused more on the foster parents than on the child’s birth parents or relatives.

In most interviews, special efforts to include birth families were not described. Instead, the respondents’ comments below are reflective of the findings:

- in general, biological families are not involved;
- health providers invite birth parents to meetings and appointments **only** through their social workers, not directly;
- birth parents said they had no access to the public health nurses who were working with their children;
- nurses have to get permission from the social worker before talking with parents about a child’s medical history;
- birth parents are allowed to attend medical appointments with their child, but little effort is made to invite them.

Because family participation was not a strength of most sites, this section describes both significant challenges and important features and characteristics.

Challenges to Involving Birth Parents and Foster Parents

Protecting children and/or involving families.

A system’s general philosophy toward families will be reflected in how families are included in health care planning and services for their children. Respondents noted that if a system focuses primarily on protecting a child from his/her parents, it is more difficult to achieve family participation in the child’s health care plan.

Overcoming policies and practices that exclude birth parents.

Many of the approaches in this study had no policies about including birth parents in their children’s health care. Instead, decisions about involving families were left to individual social workers. Respondents identified some approaches with policies and practices in place that actually **excluded** participation by birth parents. Examples included:

- a clinic that generally does not allow birth parents to attend their child’s initial health evaluation (exceptions made in recent years to facilitate family reunification);

Family Participation Continued

- clinical team meetings to review findings of multi-disciplinary assessments that do not include birth parents (social worker notifies parents of the findings after the meeting);
- health care services that are available only while the child is in out-of-home care, e.g., health advocates;
- communities in which birth families are discouraged from using (or not allowed to use) the same clinic that their children in foster care use;
- lack of after-care services (when the child returns home), or very time limited services;
- consumer satisfaction surveys that query foster parents, social workers, and providers, but not birth parents.

Funding sources that limit nurses' contact with foster and birth parents.

We found that in several communities where public health nurses work in the child welfare system, the nurses' primary responsibility is to provide support and consultation to the social workers to assist them in working with birth and foster parents on health issues and resources. In these communities, the primary Medicaid funding source for the nurse positions does not cover direct services or treatment, and thus nurses' direct contact with parents is limited.

Important Features and Characteristics

Characteristics noted by respondents as facilitating the involvement of families are described below. Features related to birth families are identified first, then foster parents, and adoptive parents.

Features Related to Working with Birth Families

The study's advisory panel members stressed that, absent child safety reasons, birth parents should be closely involved in their child's health care. The study found a few approaches that focused on reunifying children with their families of origin and tended to "pull out all

the stops", as one respondent phrased it, to provide services needed by both children and their families.

- **Focus on obtaining health history and consent from parents.** Nurses, rather than a child protection worker or court representative, talk with families during custody hearings about giving consent for their children's evaluation and treatment and about providing important health information at the time of placement
- **Offer support services such as:**
 - **Services for family members.** Some community-based clinics serve both children in foster care and their parents. Families can continue to receive care from these community clinics after reunification. In some communities, child welfare funds are used to pay for treatment for parents or other family members who are not eligible for Medicaid.
 - **Assessment of parent-child interaction.** Institutionalized comprehensive assessment of parent-child interaction followed by multiple support services for parents, based on needs identified in the assessment.
 - **Specialized training.** When children have special health care needs, training in how to care for them is provided for families at the specialized clinics serving the children. Visiting nurses also provide educational support for birth families through follow-up visits that focus on how to provide for their child's health care.
- **Involve birth parents in the health care of their children.** Families are invited to the medical screening and to all health care visits. A visiting nurse does follow-up home visits to continue education about a child's specific needs and to support parents in obtaining follow-up care.
- **Involve birth families in planning at the system level.** Very few approaches described the involvement of birth parents in system level planning, implementation, monitoring,

or policy decisions. However, a few did describe involving parents in:

- focus groups;
- serving as mentors to other parents;
- participating on community advisory groups;
- working on statewide recommendations about how to meet the health care needs of children in foster care.

Features Related to Working with Foster Families

- **Recognize the roles foster parents play in ensuring adequate health care.** Respondents generally described more ongoing involvement with foster parents in the health care approaches than with birth families. In many sites, foster parents:
 - observe and assess each child’s health care needs;
 - select the child’s primary care physician;
 - actively engage in the process of obtaining health care services for the children in their homes;
 - make medical appointments and participate in them;
 - ensure that health passports are completed and passed on to the child’s next caretaker;
 - provide care in their homes for children with special health needs.

In one site, foster parents are required by a consent decree to attend medical appointments with the child. The state attains about 50% compliance with this requirement. In this same state, foster parents receive a full written report of the comprehensive health assessment for each child living in their home.

- **Offer support services for foster parents.** To assist foster parents in filling these roles, respondents described a number of support services available to them:
 - assistance in navigating and managing the health care system and in locating providers;

- easy access to providers and health care support through 24-hour hotlines, staffed by health professionals;
- in-home assessments by mental health clinicians shortly after each child’s placement. These assessments focus on the “fit” between the foster parents and child, the need for immediate services, and the longer term supports that the family may need to care for the child;
- orientation and ongoing training on a variety of health care issues, and individualized training for children in their care who have special health care needs

- **Involve foster families in planning at the system level.** Several sites described involving foster parents in:
 - planning for and developing health passports, and in providing feedback on the use of passports;
 - foster parent satisfaction surveys related to the health care approach;
 - ongoing foster parent advisory committees.

Features Related to Working with Adoptive Families

Respondents did not provide much information about features related to working with adoptive parents. Several indicated that adoptive parents tend to use their own health care resources after adopting a child, rather than the providers the child has been using while in foster care. However, others indicated that because many children are adopted by their foster parents, they continue to use the same providers. Some specialized services were available to children after adoption. ♦

■ Attention to Cultural Issues

A 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.

The study sought to gather information about how health care approaches are designed to appropriately serve the diverse cultures represented among the children in out-of-home care, and their families. Questions were asked to determine the various cultures in the target population for each approach, if/how these cultures are represented in staffing patterns and on advisory committees, and what special strategies are used to meet their health care needs. Many respondents did not have, or had not collected, data to substantiate the percentages of children and families served from various cultures.

As in the component on family participation, a significant finding from this study is that very few respondents described “key features” related to cultural competence. The efforts to meet the needs of children and families from diverse cultures were greater in some sites than in others. However, with the exception of programs that served a large number of children and families from a specific culture, e.g., In-Care Network in Montana, respondents did not refer to their attempts to address cultural issues as strengths of the approaches. Because cultural competence was not a strength of most sites, this section describes significant challenges as well as elements for success.

Challenges in Providing Culturally Competent Health Care Services

Examples of challenges described by respondents include:

- assessment tools that are not adapted for different cultures;
- assessment teams that are primarily Caucasian working with children who are primarily African American;
- pediatricians who have difficulty addressing mental health, behavior, and discipline issues with families of different cultures;
- difficulty in finding providers who speak the language of the children served;
- written reports that are not translated into the family's native language;
- in a large urban area, foster parents and children had difficulty communicating with many physicians who are foreign born.

Important Features and Characteristics

Characteristics of approaches, noted by respondents as facilitating the delivery of culturally competent services are described below.

Develop community-based provider networks and locate clinics in the neighborhoods where children live.

These were described as two strategies to promote culturally competent health care practice. Respondents agencies in large urban areas indicated that they are establishing clinics in ethnic neighborhoods. Illinois used a community-based agency in Cook County and local health departments in other areas of the state as lead agencies that are charged with developing community-based provider networks.

Recruit culturally and linguistically diverse providers who reflect the population of children and families served.

A few respondents described attempts to expand provider networks to include providers

who represent the cultures of the children served and to maintain this information in provider profiles. Requests for providers of a specific culture are noted on referral forms.

Make written materials and health passports available in a child/family’s primary language.

The Health Passport used by HealthWorks in Illinois is written in Spanish and English.

Offer training on cultural competence.

Efforts to train staff to be culturally competent

were mentioned, including training about parenting styles in various cultures. Foster parents also are trained to work with and care for children of different cultures.

Use trained medical interpreters.

In Arkansas, interpreters are used to assist in comprehensive health assessments with children who speak Spanish, and also those who were deaf. ♦

■ 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.

Respondents described the difficulties in implementing a comprehensive approach to evaluation due to lack of time, staff resources, and funding. They also indicated the difficulty in determining individual child health outcomes for children who are in care for only a short period of time. The sites in this sample generally have not conducted objective, comprehensive program or outcome evaluations that could be used to determine the overall effectiveness of the approach or child health/mental health outcomes. However, they are making progress in several areas described below.

Important Features and Characteristics

Evaluation-related activities, common among several sites, are described below.

Measure adherence to procedural requirements.

Many sites track the number of children who receive initial screenings and comprehensive assessments, the timeliness of screenings and

assessments, the documentation of EPSDT exams and services in case records and in passports, the percentage of children who are assigned a primary care physician, immunizations received, the number of providers in the network, etc.

Track services received by the child.

A great deal of attention is paid to determining whether recommendations made in comprehensive health assessments are actually followed (see Arkansas site example in Chapter 5) and whether children with special health conditions receive follow-up care. Approaches that focus on serving young children track whether children who meet the criteria for enrollment in early intervention services actually are enrolled.

Use quality assurance approaches at all levels of the system.

A variety of mechanisms are used to monitor provider performance. In San Diego, public health nurses do on site reviews of providers. In Riverside County, CA, quality improvement staff from the county Department of Mental Health include all of the providers involved with the Assessment and Consultation Team (ACT) in the county quality assurance activities. The ACT clinicians, who authorize services, monitor the assessments and service plans completed by each provider as one method for determining provider effectiveness.

Monitoring and Evaluation Continued

Informal, word of mouth measures also contribute to the assessment of providers. In Illinois, maternal and child health (MCH) nurses monitor the quality of medical case management services provided to children in custody of the child welfare agency. This occurs on an annual basis through a medical record auditing process. Every other year, family case management agencies are required to pass a certification audit conducted by the MCH nurses. MCH nurses also provide assistance on site, on an as needed basis, to ensure the program requirements are being met.

Measure consumer satisfaction with the approach.

Satisfaction surveys are frequently used to assess how the approach is working. Providers, foster parents, and social workers are the persons most frequently surveyed. However,

we found that most sites do not survey birth parents to determine their satisfaction with the health care approach.

Track achievement of service plan goals.

Several sites evaluate their success by the achievement of each child's individual goal(s), which often focus on safety, permanency and well-being. For example, the children served by New Alternatives for Children in New York City have special medical needs, severe disabilities, and/or chronic illnesses. The initial goal is bring each child out of the hospital or institution to a placement in the community, and eventually to his/her own homes, or to an adoptive home if reunification is not possible. New Alternatives measures its effectiveness by monitoring the achievement of each family's goals and the timeliness and cost effectiveness of services provided to reach those goals. ♦

■ Training and 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.

Training was a significant component in many of the sites that were interviewed. The study determined that training is being offered to a variety of audiences, on a variety of topics, and by a variety of trainers. Families (45) and child welfare staff (42) were the most

frequently cited audiences for training. A number of approaches offered training to health care providers (23), and a much smaller number (10) trained representatives of the juvenile justice system.

Respondents indicated that training topics focus primarily on three aspects of health care for children in foster care:

- teaching stakeholders how to use and work within the program or the approach itself, ensuring that they understand how it operates;
- special health care issues that children in foster care face;
- consultation and training related to an individual child's condition, needs, and care.

Specific training topics mentioned by respondents were:

- child development
- attachment and bonding

- advocating for health care
- infectious diseases
- failure to thrive
- the impact of child abuse and neglect on a child's health
- premature birth
- prenatal drug and alcohol exposure
- lead poisoning
- caring for children with HIV/AIDS sexually transmitted diseases
- Early and Periodic Screening, Diagnosis, and Treatment
- medications
- medical conditions that children in custody are at-risk for
- fetal alcohol syndrome
- speech and language development and disorders
- red flags for hearing problems
- early intervention services
- malnutrition and feeding disorders
- working with children who are medically complex
- identification of community health resources.

Most frequently the trainers were program administrators, nurses and other health or mental health clinicians who worked in the approach, and sometimes experienced foster parents who trained new foster parents or birth parents.

Important Features and Characteristics

Features noted by respondents in several sites as facilitating training are described below:

Institutionalize training at all levels of the system.

Make training on health care issues for children in foster care an established part of new worker training, in-service training, core training for new foster parents, and ongoing training for foster parents. Several sites

developed modules on health care for children in foster care that were continuously used in these training sessions.

Train families in their own homes.

Hands-on, in-home training for families whose children have very special medical needs is provided by nurses. For children in foster care this occurs most often in foster homes; however, a number of sites provide the same type of training for birth families who are working on reunification. In one state, foster families work with birth families to be sure that they both use the same procedures with the child.

Offer informal consultation.

A great deal of training occurs informally through co-location—when nurses or mental health clinicians are housed in the same office as social work staff; by including nurses in multidisciplinary team meetings; through articles in foster parent newsletters; and one on one consultations when families visit foster care clinics.

Use community colleges.

Community colleges were described as an excellent resource for offering training.

Provide cross-system training.

In Ventura County, California, new social work staff and new foster care nurses participate in the same orientation and training. A number of sites described strategies for providing information to judges and court staff on health care issues.

Train medical students.

Rotations in foster care clinics provide a unique opportunity for medical students, nursing students, pediatric residents, and others to learn about the special health care issues for children in foster care. ♦

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 ensure 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.

The study determined that Medicaid (39) and state funds (31) are the primary funding sources used by the sites in this sample for health care services for children in foster care. However, many sites also are using other funding sources to support health care services for children in foster care. These include local funds (17), grant or research funding (16), Title IV-E (6), Title IV-B (2), Title V (1), and the Social Services Block Grant (1).

Twenty-three sites described one or more additional funding sources, which included: donations, private foundations, Department of Labor, Federal Court Improvement Projects, system of care grants, endowments, universities (especially medical centers), Bureau of Indian Affairs, Indian Health Services, Tribal Funds, Individuals with Disabilities Education Act (IDEA), and the Victims Witness Program. Title IV-E funds, identified by only 6 sites, were used primarily to train caregivers and social workers.

Important Features and Characteristics

It is clear from the many funding strategies described by respondents that state and community leaders understand how to use multiple funding sources that are targeted for different aspects of health care, e.g., treatment services, care coordination, data management, administration, and training. Characteristics of

these strategies, noted by respondents in several sites, are described below.

Use Medicaid funds strategically.

Medicaid funds were used to cover administrative costs, case management, and clinical services. Two noted categories of Medicaid funding are targeted case management and skilled professional medical personnel (see site example in Chapter 5). Several sites offer enhanced Medicaid rates, e.g., in some states initial screening and comprehensive assessments can be billed at higher rates for children in foster care. Salaries for clinical staff in some approaches are covered through Medicaid reimbursement.

Create mechanisms to cover administrative costs.

State funds are used by some sites to cover administrative costs that are not funded by Medicaid. Administrative expenses for the comprehensive assessment program in Arkansas are paid by the Division of Children and Family Services through a contract with the university that administers the program. In Illinois' HealthWorks program, the Department of Children and Family Services contracted with the Department of Human Services and also with an organized consortium of community-based agencies to establish community-based lead agencies to administer HealthWorks throughout the state.

Use funds from several systems.

Many approaches included funding from several different agencies. What one source was unable to fund, another source funded. For example:

- in one county where visits to the foster care clinic cost more than Medicaid reimbursement allows, the Department of Health absorbed this additional cost for a period of time;
- Medicaid does not pay for “no shows”, so in Arkansas, the Division of Children and

Family Services pays when children do not appear for their comprehensive evaluations. (This practice has significantly reduced the number of “no shows”.)

- in Riverside County, CA, because almost all health services provided for children in foster care are Medi-Cal reimbursable, the Department of Public Social Services (DPSS) has reduced its cost for treatment services. However, if a parent or family member needs treatment and is not Medi-Cal eligible, DPSS funds can be used to pay for services for these family members.

Use fiscal incentives to encourage provider involvement and the provision of special services.

In addition to the enhanced rates for specific services, respondents described other fiscal

incentives to get providers to participate in the approach, e.g., in Illinois, a one-time \$15 fee is paid to providers who initiate a health passport, and a \$5/child/month patient management fee is paid to primary care physicians in Cook County.

Private foster care agencies, generally in large urban areas, described a range of medical per diem rates that they receive from the public child welfare agency to cover costs for a child’s medical care. Services a child receives in a foster care clinic that is run by the private agency are covered through such a per diem rate. One agency described a three tiered rate system in which the per diem rate for children who are medically fragile is seven times higher than for children in “regular” foster care. ♦

■ 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, the approach ensures that the special needs of children in custody 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 ensure 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.

Less than a third of the sites that were interviewed (21) described extensive issues or involvement with managed care; however, some of the positive features and efforts they described were very significant (see individual site examples in Chapter 5). They also described some specific challenges related to working in a managed care environment, thus in this section we describe both.

Challenges of Managed Care

Paying for early intervention services.

Providers of developmental assessments and services described difficulty in getting payment for these services from HMOs. For example, in one county, prior to managed care, Medicaid paid for pediatric evaluations by specialists. After managed care, these evaluations were offered by the child’s primary care physician within a capitated rate. In another county, a provider of mental health and developmental assessments for children under age three was concerned about convincing the managed care

Designing Managed Care to Fit the Needs of Children in the Child Welfare System Continued

entity that such services for young children are mental health services that should be covered by the behavioral health plan.

Dealing with medical necessity criteria.

In-Care Network, a therapeutic foster care program in Montana for American Indian youth who have serious health or mental health conditions, described difficulties related to medical necessity criteria after Montana implemented statewide utilization management in October 2000. To access Medicaid funds for therapeutic foster care, youth must now carry certain diagnoses. The American Indian culture focuses on strengths rather than deficits, but finds that it must identify weaknesses in order to meet the criteria for services. Also, alternative, culturally-appropriate healing services usually are not covered.

Important Features and Characteristics**Set up a process to assist families and social workers in navigating the managed care system.**

Some sites had identified special liaisons or special units in the public child welfare agency to work closely with the managed care organizations (MCOs). These units focus on enrolling children in the most appropriate managed care plan—often based on which

providers are available in the plan. They assist foster families in finding providers and in understanding how the managed care system works. They address continuity of care as children move from one placement to another. They also offer training to MCOs on how the child welfare system works and about the unique health care issues of children in foster care.

Assess whether to serve children in foster care through a managed care approach or on a fee for service basis.

Another strategy described by a number of states is to provide health care services for children in foster care on a fee for service basis by disenrolling them from managed care plans when they come into care. In some states, this happens automatically for all children who enter foster care. In some states children in foster care must be served in managed care, and other states have the option of disenrolling them. One California county described how a clerical worker does “emergency disenrollments” from the managed care plans, and a new Medi-Cal card is given to foster parents to cover medical and dental services. In New Jersey, children who are medically fragile are excluded from managed care and remain on fee for service. ♦

Additional Important Features and Characteristics

The study discovered several other very important key elements for success that crossed multiple components in the comprehensive framework.

Nurses play a significant role in the foster care system.

Respondents from many sites described nurses as a previously untapped resource for serving children and families in the child welfare system. They depicted nurses, with their health care knowledge and experience, as essential members of the child welfare team. The multiple roles described for nurses included:

- conducting initial health screenings;
- performing or referring children for comprehensive assessments;
- collecting and maintaining health information;
- care coordination and medical case management;
- developing health care plans;
- monitoring follow-up care;
- using their health care knowledge to interpret medical reports; provide consultation and training; educate providers about the special needs of children in foster care; and to participate in service planning, child protective investigations, and court hearings;
- assisting parents with health care issues as children and families are reunified;
- coordinating sexual abuse evaluations;
- managing the health care for children who are medically fragile.;
- advocating for health care services;
- providing on-call services;
- administering clinics.

Creating the right management structure is important.

Respondents noted the importance of creating a structure to effectively manage the approach.

The management structure depends upon the number of children and families to be served, the goals and purpose of the approach, the prevailing collaborative philosophy in the community/state, and the resources available.

Strong leadership and commitment to a vision are essential.

In seven of the nine sites visited, the creation and implementation of the approaches were attributed to the vision and commitment of one or more key leaders. Respondents stated that without these leaders, the approach would not have been successful, nor would it have been sustained. Trust, accessibility and a belief in the value of every child having a right to comprehensive health care were leadership qualities most often depicted. To successfully implement an approach requires commitment and ownership by influential people and systems, endless energy, and political will

Positive relationships across and within systems are crucial.

Many programs described the importance of informal relationships—across agencies, with community providers, and internal relationships among staff in sustaining the effort, especially when confronted with challenges.

Flexibility and responsiveness are necessary traits.

To be effective, many respondents felt that an approach must be flexible, responsive, and able to change as lessons are learned and child, family and system needs change.

Continuing Challenges to Providing Comprehensive Health Care

We asked multiple stakeholders in each of the nine sites visited about ongoing challenges. Even though implementation dates in these sites range from 1987 to 1997, with half of them in operation for at least 10 years, many continue to experience and to work on

resolution of significant challenges. A few of the most noted continuing challenges are described below.

It is difficult to complete comprehensive health assessments within specified time frames.

The daily realities of life, such as foster parents' busy schedules, make it difficult to complete comprehensive assessments in a timely manner. Some children are in and out of care so quickly that they are not evaluated, or if evaluated, identified problems are not addressed.

Even though health passport systems exist, it is difficult to ensure that the passports will be filled in.

Completion of the passports is dependent upon numerous individuals—foster parents, providers, case workers, public health nurses, and clerical staff. It is difficult to monitor all of them, and they do not all share the same belief in the value of a passport.

Communication breaks down at transition points.

When children move from one placement to another, when they return home or to another permanent setting, when they transition out of foster care as an adult, health care issues may not be addressed and health information is often not passed on.

It is a challenge to integrate physical health and mental health care.

While several of the approaches focus on obtaining adequate physical health care, they have not created a system to improve access to mental health care. Primary care physicians refer mental health issues back to the case worker.

Mental health, dental, and vision services continue to be difficult to obtain.

A lack of qualified providers continues to be a problem in many areas.

More focus on comprehensive program and outcome evaluations is needed.

Inadequate funding and resources to develop comprehensive program evaluations means that even though sites are implementing creative approaches, they may not be able to obtain information about changes in actual child health outcomes, nor to determine how well the chosen strategies are actually working.

Remaining Gaps in the Type of Approaches Offered

In analyzing the types of approaches that are offered in this study's sample, we found important approaches to providing health care for children in foster care that are missing. These gaps include approaches:

- to providing appropriate health care services for adolescents;
- for strengthening participation by birth families and kinship care providers;
- to providing mental health services for children with mild to moderate mental health needs;
- to providing dental care;
- to meeting a child's health care needs at transition points;
- to offering appropriate health care services for children of color, even though there is a disproportionate representation of children of color in the child welfare system.

CHAPTER 5

Individual Site Examples

Discussed in this Chapter

- Brief practical examples of how some states, communities, and individual programs are implementing the eleven critical components of the framework for comprehensive health care

Chapter 5 offers the reader illustrations from individual sites that describe how they are implementing the critical components of the framework for a comprehensive approach to health care for children in the foster care system. The individual site examples in this chapter focus **only** on the component that is being discussed. Additional information about a larger array of activities in each site can be found in several other places:

- for the nine sites that were visited, summary descriptions are provided in Chapter 2 of this document, and detailed individual site visit reports are available on our website,²² or in hard copy from the Georgetown University Child Development Center;
- individual fact sheets describing most of the approaches that were interviewed are available on our web site and in print;
- *Strategies for Implementation*, a companion document to this one, offers examples from individual sites of many strategies being implemented in states and communities;
- to request further information from the sites themselves, see Appendix A for contact information for all examples described in this chapter.

Components of a Comprehensive Approach

- initial screening and comprehensive health assessment
- access to health care services and treatment
- management of health care data and information
- coordination of care
- collaboration among systems
- family participation
- attention to cultural issues
- monitoring and evaluation
- training and education
- funding strategies
- designing managed care to fit the needs of children in the child welfare system

²² Website address: <http://gucdc.georgetown.edu/foster.html>

■ Initial Screening and Comprehensive Health Assessment

Initial Health Screens

HealthWorks of Cook County, Cook County, Illinois

HealthWorks is set up to provide an initial health screen before children are placed. The purpose of the initial screen is to treat any acute medical needs, document the presence or absence of medical problems, document and treat any signs of physical or sexual abuse and/or neglect, assess and treat any infectious diseases, and to provide medical information needed for making an appropriate placement for the child.

In Cook County (Chicago area), hospital emergency rooms are the primary providers for the initial screen because they are open 24-hours per day and are community-based. HealthWorks has contracted with specific ERs that have agreed to screen children within one hour of their arrival at the site. In exchange for providing immediate service, the hospitals receive increased rates for each screen that is completed. A copy of the initial health screen is placed in the child's Health Passport and is given to the substitute caregiver.

At the time of placement, all children are assumed eligible for Medicaid as a family of one and are given a temporary Medicaid Card.

Comprehensive Health Assessments for Children and Their Families

Westchester Institute for Human Development, Family Program, Westchester County, New York

The Family Program focuses on families during the assessment process. While each child receives a comprehensive developmental, behavioral and mental health assessment, the Family Program also routinely includes birth parents in the assessment process. Families are invited to provide health, developmental and family history. Parent and child interaction and parental functioning are also assessed. These assessments are used to help plan the supports and services families may need.

Children are assessed in their foster homes as well. A psychologist visits each foster home within three weeks of a child's placement to assess the "fit" between the foster home environment and the child and to identify the need for immediate and ongoing supports to maintain the child's placement.

Physical health assessments are provided for each child within 10 days of entering foster care at the Department of Social Services Pediatric Unit, a health care clinic staffed by two part-time pediatricians and three full-time registered nurses.

Mental Health Assessments in Shelter Care Homes

Assessment and Consultation Team, Riverside County, California

Riverside County places children who enter foster care in temporary "shelter care" in family homes for up to 30 days until the court decides whether to transfer parental custody to the child welfare agency. Clinicians conduct mental health assessments of all children age 3 and over in shelter care homes. Using an assessment form to guide the evaluation process, they visit the home to talk with the shelter parent and with the child. The purpose of the assessment is to explore how the child feels about his/her placement, to assess need for immediate treatment, and to determine whether a more comprehensive mental health assessment is needed. This early assessment offers an opportunity for children to discuss difficult issues, provides support for the shelter parents, and gives them someone to call in a crisis.

■ Access to Health Care Services and Treatment

Ensuring Access to Treatment

The Managed Care Unit, Philadelphia Department of Human Services

In 1997, when the approximately 8,000 children in foster care in Philadelphia were enrolled in Health Choices (Medicaid managed care in southeast Pennsylvania), the Philadelphia Department of Human Services (DHS) created a Managed Care Unit (MCU) to:

- ensure that the managed care system could accommodate the special circumstances of children in substitute care;
- provide access to appropriate and necessary medical care; and
- help children and their families navigate the managed care system.

The social workers with case management experience who form the unit understand foster care, Medicaid policies and rules, and how managed care works. They know the impact of placement changes on a child's eligibility and facilitate continuity of health care as a child's placement changes. They help determine which HMO a child should enroll in and negotiate with HMOs to meet each child's health care needs. They also make sure health care providers receive payment.

DHS contracts with private child welfare provider agencies for all out-of-home placement services. Each child welfare provider agency has appointed a health liaison who communicates regularly with the MCU about health care services for the children placed with the provider agency. The MCU also offers training on managed care for child welfare provider agencies, for DHS case managers, and for foster parents.

Strengthening the Provider Network

Child Health and Disability Prevention (CHDP)²³ Provider Unit, San Diego County, California

The CHDP Provider Unit is a unit within the County of San Diego Health and Human Service Agency that offers support to the CHDP Foster Care Program (see approach description in Chapter 2). It is staffed by public health nurses and focuses on strengthening the provider network available to children in foster care and other children served by the CHDP program.

One of the major tasks of the public health nurses in the CHDP Provider Unit is to ensure that sufficient numbers of qualified medical providers are available. There are approximately 230 CHDP providers in San Diego County. They are a specialized group of Medi-Cal providers who are qualified to perform CHDP exams and are allowed to bill Medi-Cal for a wider array of well-child services because of broader billing codes. Foster parents receive an updated list of CHDP providers each time a child is placed with them.

Some of the responsibilities of the public health nurses in the CHDP provider unit include:

- recruiting and certifying new providers;
- monitoring providers for quality assurance;
- completing an initial site review for new providers and then updating site reviews every three years;
- reviewing and revising standards for providers annually, or as needed;

²³In most other states, the program that California identifies as CHDP is referred to as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funded with federal and state Medicaid funds.

- acting as the liaison to Medi-Cal managed care plans.

The public health nurses also provide multiple support services for the CHDP providers:

- monthly provider orientation
- in-service sessions for existing providers
- bulletins which include updates on health care issues, fee increases, and compliance with required paperwork.

Accessing Specialty Medical Care

The Children’s Aid Society, Mount Sinai Medical Center Collaboration, *New York City*

Approximately 700 children in foster care with The Children’s Aid Society receive primary care services at the agency’s Midtown Manhattan clinic (co-located in the same building as the agency’s social work staff) and at community-based clinics in Harlem and the South Bronx. These clinics offer on-site medical, dental, and mental health services. Pediatric nurse practitioners and a full-time pediatrician provide many direct services. Nurse practitioners offer health care management for children in foster care.

Through its collaboration with Mount Sinai Medical Center the children in placement at The Children’s Aid Society also have access to specialty pediatric clinics. A few years ago, the agency began to formalize an existing relationship with Mount Sinai Medical Center (which had been seeing many of the children from The Children’s Aid Society) in order to capitalize on the existing strengths of the two institutions. Pediatricians from Mount Sinai are placed in The Children’s Aid Society foster care medical clinics. The Medical Director for The Children’s Aid Society is also on the Mount Sinai faculty. The two organizations have established a cooperative referral process, guidelines, standards of care, and procedures for integrating services and coordinating care. While The Children’s Aid Society still utilizes other referral sources for some specialty services, children have access to 29 specialty pediatric clinics through Mount Sinai.

■ Management of Health Care Data and Information

Standardized Health Forms

HealthWorks of Illinois

Providers who participate in the HealthWorks network must use standardized health record forms. This is to ensure that children receive health care according to EPSDT standards and also to provide a permanent and uniform central health record for each child. Standardized forms include age-specific well-child health visit forms, acute care visit forms, referral forms, a comprehensive history form, and a problem list and immunization form. To maintain a central record, the providers send one copy of each of these forms (except the problem list and immunization form) to a lead agency which maintains a central file for each child. The lead agency in Cook County is a community-based consortium of provider agencies. Nineteen health departments serve as lead agencies in the remainder of the state.

Blending Health Data into Child Welfare Information Systems

Fostering Healthy Children, *State of Utah*

Fostering Healthy Children, a statewide program in Utah, provides health care case management for children in out-of-home placement. Maintaining a computerized data system based on health visit forms that health care providers complete is one of the responsibilities of

the 13 public health nurses and 9 support staff involved in the program. The computerized case management system, called SAFE, tracks the physical, dental, and mental health services and histories of each child. The database is part of the state's automated child welfare information system that contains all child welfare data. Reports are available through the Internet to users who have special security clearances.²⁴

This system also allows the nurse case managers to track over time whether improvement is made in a child's health status. Each child's health status is rated in one of six categories at the time of the initial and follow-up health assessments (within 5 days and 30 days of placement). As each child's health status changes from one category to another, the nurses record this in the computerized case management system. Aggregate reports can be provided from this system.²⁵

■ Coordination of Care

Health Care Coordination

Rx for Kids Program, Ventura County, California

Rx for Kids is a collaborative effort between Ventura County Public Health and Ventura County Children and Family Services (CFS) to assure that the health care needs of children in foster care are identified and met, to reduce the risk of poor health outcomes for children in protective custody, to assure that they receive timely and comprehensive health assessments, and to track and document the receipt of appropriate treatment services. The program also provides cross-training as newly hired social workers and nurses are trained together. One to two public health nurses are housed in each of the three county CFS regional offices and at the CFS court unit.

Upon referral from child welfare workers, the public health nurses support the social workers in coordinating a child's health care by:

- conducting health risk assessments in abuse, neglect or exploitation situations to strengthen the worker's ability to determine health and safety needs;
- identifying and providing special services for children with special health care needs;
- ensuring that the health care needs of children in foster care are identified and met.

Some of the specific services provided by the Rx Program nurses include:

- training for foster parents and child welfare staff on health issues;
- obtaining training for parents and caregivers from home health nurses and other community resources on health issues specific to their children;
- consultation with the social worker and/or family on any health related issues;
- interpreting medical reports;
- assisting with individual health care plans;
- conducting in-home assessments of child growth, development, health status, parent/child interaction;
- providing assistance to social workers in identifying parental/caregiver drug use;
- linking families with appropriate community resources.

²⁴ Dicker, Sheryl, Elysa Gordon and Jane Knitzer. *Improving the Odds for the Healthy Development of Young Children in Foster Care. Promoting the Emotional Well-being of Children and Families.* New York City: National Center for Children in Poverty, 2001.

²⁵ Rawlings-Sekunda, J., H. Balken and L. Bannister. *Efforts in Ensuring Health Care to Children in Foster Care: Case Studies of Nine States.* Portland, ME: National Academy for State Health Policy, 1999.

At the time of the telephone interview, Ventura County was discussing strategies for expanding the Rx for Kids Program to serve children living in their own homes (family preservation and family reunification—follow-up services).

■ Collaboration Among Systems

Building a Collaborative Spirit

In-Care Network, Billings, Montana

In Montana, In-Care Network, Inc. provides therapeutic foster care services for American Indian youth who have serious health or mental health conditions. Approximately 60-70 youth are served by In-Care in therapeutic foster homes. In-Care believes that the unmet needs of the Indian child can be healed and treated through a holistic approach to human services and that the entire Indian community must take ownership of the process and be involved in developing solutions.

Collaboration is a cornerstone of In-Care's success. The agency works closely with other community organizations and providers. Formal collaborations exist with the Montana's Indian tribes and with state government in Montana. In-Care's holistic perspective keeps the youth's needs at the center. It views collaboration with other organizations and the family as part of an holistic approach with families and children. Collaborating agencies are not part of a hierarchy, but all are part of a Team Service Wheel, with the child in the middle. Decisions are made by consensus. This requires a significant time commitment.

Collaboration with the Courts

Permanent Judicial Commission on Justice for Children, New York

The Permanent Judicial Commission on Justice for Children in New York, composed of judges, advocates, physicians, social workers, legislators, and state and local officials, found that many children in foster care had serious health needs that could compromise their healthy development and efforts to secure a permanent home. They also discovered that such issues were often neglected during child welfare court proceedings. To address this, the commission worked together to create a *Guide for Judges, Advocates and Child Welfare Professionals* with a checklist of 10 health-related questions that at least one person involved in the court process—one judge, one lawyer, one law guardian, one Court Appointed Special Advocate (CASA)—should ask during court appearances. The Commission hopes that inquiring about a child's needs will ensure that services are provided. If resources are inadequate, the Commission hopes that judicial leadership will help spur new initiatives.²⁶

Training has been provided statewide (and nationally) to those involved in the court process and to those who provide health and developmental services on how to use the 10-question checklist to promote the well-being of children in foster care. Pilot projects using CASAs to collect data on the use of the checklist, to create a health profile of children in foster care, and to document barriers to services have been undertaken in Erie and Westchester Counties.

²⁶ New York State Permanent Judicial Commission on Justice for Children. *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals*. White Plains, NY: Permanent Judicial Commission on Justice for Children, 1999.

■ Family Participation

Family Participation

St. Christopher's, Inc., Family Healthcare Network, New York City

St. Christopher's, a private, not-for-profit, multi-service agency for children and families in New York City, operates community-based health clinics to serve children placed in its foster care program and their families. The clinics, located in Harlem, Brooklyn, the Bronx, Upper West Side of Manhattan, and Bedford Stuyvesant, also serve other individuals who are Medicaid eligible. Because the clinics are community-based, in the neighborhoods where the children are placed in foster care and where their birth families live, they are able to serve the children and their families, both during placement and after families are reunified.

St. Christopher's goal is to reunify families as quickly as is feasible. The organization believes that health care providers should treat not only the child, but the entire family. Families (both birth and foster) are invited to attend medical appointments with the child. They learn about the child's medical condition during the appointment. When needed, a visiting nurse does follow-up home visits to continue education about a child's specific needs. St. Christopher's encourages birth parents to use the clinics for their own primary care, and through partnerships with other health care entities, guarantees them access to specialty medical, mental health, and substance abuse services.

In the early planning stages for the clinics, parents were consulted about their needs. They also serve on the community advisory groups. Clinic staff reflect the cultures of the communities they serve. The 24-hour answering service is multilingual.

■ Attention to Cultural Issues

Meeting the Needs of American Indian Children and Families

In-Care Network, Inc., Billings, Montana

One reason we selected In-Care Network in Montana as a site to visit was to learn about strategies for serving American Indian children and their families in a therapeutic foster care program and in the greater health care system. Key features of In-Care Network related to cultural competence include the following:

- **Operating in “dual worlds”.** As the children themselves must live in two worlds, agencies serving them must also. In-Care navigates continuously between the non-Indian/predominantly Caucasian and the American Indian worlds. It builds bridges between Native agencies and white agencies, e.g., it understands and works with tribes while also working within state policies and laws and managed care.
- **Involving the community.** The entire Indian community takes ownership of a child and helps develop solutions.
- **Staff and foster parents represent the culture of the child.** Almost all the staff working at In-Care Network are Indian, and two-thirds of the foster parents are Indian, living both on and off the reservations.
- **Individualized treatment planning.** Helping youth to become aware of and maintain their heritage is part of the healing process, but this process is not the same for all Indian youth. One difference between many of the youth is whether they have lived in cities and towns or on a reservation most of their lives. In-Care uses this information to incorporate appropriate cultural interventions into the treatment plan.

- **Promoting a child’s identity and feelings of acceptance through cultural/educational activities and programs.** Several activities offered by In-Care include: Vision-Seekers (for older youth), Grandchild Journey (for youth 3 to 12), Camp Little Feather (for youth 4 to 11), Sweat Lodge, Naming Ceremonies, Pow-wows.
- **Developing outcome measures normed on Indian youth.** In-Care is working with Medicaid to get such measures approved.

■ Monitoring and Evaluation

Tracking Follow-Up Services

Project for Adolescent and Child Evaluations (PACE), State of Arkansas

The Project for Adolescent and Child Evaluation (PACE) is a collaborative effort between the Division of Children and Family Services (DCFS) and the University of Arkansas for Medical Sciences (UAMS). The main goal of PACE is to provide comprehensive multidisciplinary evaluations for all children within 60 days of entering foster care and to ensure that needed follow-up services, based on recommendations from the comprehensive evaluations, are received. PACE tracks these two main compliance issues:

- percentage of children receiving a comprehensive assessment within 60 days;
- 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, each month UAMS selects a random sample of 60 children for whom comprehensive assessments were conducted three months earlier. DCFS health care specialists are asked to provide documentation of completion of the recommendations. Monthly and quarterly reports of the results are then sent to DCFS staff and administrators.

The program’s evaluation process revealed that, for the most part, follow-up services were being received. However, in one county, where social workers were having difficulty following-up on the recommendations, a patient care coordinator (with experience in the health care field) was added to the UAMS team to assist this county in following-up on service recommendations.

■ Training and Education

Pediatric Training for Juvenile Court Judges and Social Workers

Sacramento County, California

Sacramento County is implementing four distinct approaches to better meet the health care needs of children in foster care. One of these approaches provides judges and court staff with needed medical information. Shortly after Sacramento County implemented a “no tolerance” policy for parents who abuse drugs, the number of children and families appearing before the juvenile court increased dramatically, and judges frequently requested pediatric consultations. This process was formalized by developing a half-day training course for judges, attorneys, and social workers entitled “Pediatrics 101”. Training content includes health concerns in infants, toddlers, and children; dental and ocular problems, child development and behavior problems, and strategies for navigating managed care. A document with health resources and information (e.g., immunization schedules) and county health contacts is provided. Each judge also receives

a set of medical reference books, a practice which evolved from nurses reporting that they were being asked to “bring their books to court”. Also being developed is a medical consultation program for judges—to provide 24-hour, 7-day a week advice to judges and referees who must often authorize complex health treatments and procedures for children in foster care.

Social service staff are invited to participate in the judicial training; however, the county is planning to develop more intense (1-2 days) basic pediatric training for all social workers in collaboration with UC Davis Medical Center, Department of Pediatrics.

Curriculum Materials and Video

Parent Educational Advocacy Training Center (PEATC), Fairfax County, Virginia

The Caring Communities for Children in Foster Care Project, a collaborative effort between the PEATC and Fairfax County, Virginia child-serving agencies funded by the Maternal and Child Health Bureau Integrated Services Initiative, has produced issue briefs, guides, and a video that can be used in training multiple audiences about health care services for children in foster care. The three separate guides are targeted for health care professionals, social services professionals, and foster parents. They accompany the video entitled *Fostering Health in the Foster Care Maze*. The 28-minute video shares the wisdom of biological parents, foster parents, social workers, physicians and advocates as they have successfully negotiated services in the foster care maze. Four issue briefs developed by the project are available on line at www.peatc.org/FosterCare/overcoming_barriers.htm.

■ Funding Strategies

Medicaid as a Funding Source for Nurses in the Foster Care System

Child Health And Disability Prevention (CHDP)²⁷ Foster Care Program, San Diego County, California

For its Child Health and Disability Prevention Programs, San Diego County has hired public health nurses who meet the designation of Skilled Professional Medical Personnel (SPMP) to conduct various activities claimable under Medi-Cal. The function codes specific to a public health nurse working with children in foster care include the following:

- SPMP Administrative Medical Case Management
- SPMP Intra/Interagency Coordination
- SPMP Collaboration and Administration
- SPMP Training
- SPMP Program Planning and Policy Development
- Quality Management by SPMP.

The public health nurses that work in the CHDP Foster Care Program do not provide direct services to children and families because direct services are not funded through these particular funding codes. Respondents indicated that some other counties in California have blended funding sources so that foster care nurses can do home visits and more direct services.²⁸

²⁷In most other states, the program that California identifies as CHDP is referred to as Early and Periodic Screening, Diagnosis, and Treatment (funded with federal and state Medicaid funds).

²⁸For additional information about strategies for funding the services of public health nurses, see *California Statewide Guidelines for Public Health Nursing in Child Welfare Service*. California Department of Health Services, Children’s Medical Services Branch, Child Health and Disability Prevention Program, (1999): Appendix C.

Additional funding strategies used in San Diego include the following:

- The county used funding from one public health nurse position (mostly county funds) to serve as the local match for the first four public health nurses that were hired for the CHDP Foster Care Program (each at a 75% federal, 25% local rate).
- When children who are eligible for Medi-Cal and are enrolled in an HMO enter the county's emergency shelter at Polinsky Children's Center, they are disenrolled from the HMO to allow the Center to bill Medi-Cal for their medical evaluations.
- Health care providers, who qualify as CHDP providers and are qualified to perform CHDP exams, are allowed to bill Medi-Cal for a wider array of well-child services because of broader billing codes than regular Medi-Cal providers.
- Billing rates for CHDP exams are enhanced.

■ Designing Managed Care to Fit the Needs of Children in the Child Welfare System

Navigating Managed Care

The Managed Care Unit, Philadelphia Department of Human Services

See description under Access to Health Care Services and Treatment (in this chapter).

Accessing Behavioral Health Services in a Managed Care Environment

The Behavioral Health and Wellness Support Center, Philadelphia Department of Human Services

In December 2001, the Philadelphia Department of Human Services (DHS) established a Behavioral Health and Wellness Support Center (BHWSC) to improve access to behavioral health services for children and families involved with DHS, and to the extent possible, to integrate behavioral health and DHS operations and services. The BHWSC is a result of collaboration among a number of city agencies: Department of Human Services, Community Behavioral Health Managed Care, Office of Mental Health, Office for Mental Retardation Services, Early Childhood Development Services (in OMR), and the Coordinating Office for Drug and Alcohol Problems.

Primary tasks of the BHWSC include:

- managing a help desk to assist DHS and DHS provider agencies in accessing behavioral health services and resolving cross-system problems;
- advocating with the behavioral health system for families involved with DHS and for DHS staff;
- ensuring rapid discharges from psychiatric hospitals for children involved with DHS;
- promoting timely and comprehensive discharge planning for children who are aging out of the DHS system and into the adult behavioral health system;
- providing clinical consultation;
- securing behavioral health assessments and interpreting them for DHS staff and for DHS provider agency staff;
- providing clinical direction to DHS staff in sexual abuse and sexual health issues;
- securing permanency evaluations for children in very complex situations.

The agencies involved also work together on joint program and resource development activities, such as the development of a more extensive treatment foster care program and provider network. Communication between the BHWSC and the city's behavioral health organization, CBH, is continuous. Both organizations work together to solve problems and to determine each child's needs. The mission is to find the right services for the child and to then work out payment responsibility. If this is not clear, higher level administration determines who pays.

Assessment and Consultation Team, Riverside County, California

When the state of California passed legislation in 1997 assigning responsibility for Medi-Cal mental health managed care to the county mental health departments, the Department of Mental Health (DMH) became the formal access point for community-based mental health treatment services for all individuals on Medi-Cal in Riverside County. Development of the Assessment and Consultation Team (ACT) began immediately after DMH became the managed care entity for behavioral health services. ACT was created through an interagency agreement between the DMH and the child welfare agency, the Department of Public Social Services (DPSS).

In this approach, licensed mental health clinicians who work for DMH, the managed care entity, are housed at child welfare offices throughout the county to initiate the process of obtaining coordinated community-based mental health services for children receiving child welfare services. DPSS refers children who need a mental health assessment or community-based counseling services to the ACT clinicians who are responsible for:

- determination of treatment to be authorized (through the Community Mental Health Center's behavioral health managed care plan);
- initial referral/authorization for mental health services; and
- routine review of mental health treatment plans and requests for extension of services.

The ACT clinicians also provide consultation to DPSS social workers regarding mental health issues related to the children served by DPSS and do direct clinical assessment of children served by DPSS whose clinical needs are unclear. Additionally, all children ages 3-18, who live in shelter care homes (initial placements after they are removed from their own homes), receive clinical assessments within 30 days.

CHAPTER 6

Summary of Advice and Recommendations

Discussed in this Chapter

- Analysis of the recommendations and advice from all respondents related to implementing the components of the comprehensive framework²⁹
- Overarching policy and practice recommendations based on the findings of the study

Throughout this document, we have discussed the importance of creating a comprehensive, community-based health care system that includes the 11 specific components described in Chapter 3. While the creation of this framework is itself a finding of the study, we also have used it in previous chapters to organize specific study findings. We use it once again in this chapter to help sort and understand the many recommendations and advice offered by respondents.

Major Recommendation

The framework also serves as **our first and major recommendation:**

The challenge is to strengthen service capacity and to create a comprehensive health care system for children in foster care that integrates health and social services for each child and family.

States and communities that face this challenge would benefit from using the comprehensive framework described in Chapter 3 to begin a dialogue about what needs to be accomplished and how to move forward.

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;
- address how to make improvements.

Recognizing that every community has different experiences, needs and resources on which to build, the comprehensive framework is not meant to be prescriptive, but rather to be thought provoking and to provide a range of ideas to discuss.

²⁹ For advice and recommendations about how to implement specific approaches similar to those implemented in the nine sites that were visited, see the individual site visit reports on the web at <http://gucdc.georgetown.edu/foster.html>, or request printed copies of the reports from the Georgetown University Child Development Center.

Most important is to engage in careful and purposeful thinking about the issues.

In this process, it also is helpful to review standards created by other national organizations that provide more detailed information and practice parameters such as: the 1988 Child Welfare League of America (CWLA) *Standards for Health Care Services for Children in Out-of-Home Care*, the 1994 standards developed by the American Academy of Pediatrics in conjunction with the 1998 CWLA standards, and a resource manual offered in 2002 by the American Academy of Pediatrics, District II in New York entitled *Fostering Health: Health Care for Children in Foster Care*.

Recommendations for Each Component

The definitions for each component in the framework describe **what happens** and **what services are offered** for children and families in an ideal system (see Chapter 3). Most component definitions also provide suggestions as to **how** they should be implemented. Thus, each definition serves as the overarching recommendation for each component. Additional and more specific recommendations offered by respondents are listed below for each component. Some of these recommendations are cross-cutting and are applicable to several components in the comprehensive framework.

■ Initial Screening and Comprehensive Health Assessment

1. Develop a **system** to identify and refer all children for assessments, to track when assessments occur, and to monitor follow-up on recommendations made in the assessment. Include procedures for conducting reassessments at transition points in children's lives.
2. Adjust Medicaid eligibility procedures so that children who enter foster care are instantly eligible, and Medicaid funds are available for initial screenings and

any health care services that are needed immediately.

3. Given the trauma that children experience when they enter care, make their comfort and state of mind major factors in setting up screening and assessment locations and processes.
4. Locate assessment sites within a reasonable distance from a child's home and make them accessible to all children and families.
5. Ask an adult who knows the child well to accompany him/her to the comprehensive assessment in order to provide needed information and to assist the child through any difficulties.
6. Select providers to conduct screenings and assessments who reflect the various cultures represented by the children and who are familiar with the child welfare system.
7. Focus assessments on the strengths and needs of the child's family, as well as on the child.

■ Access to Health Care Services and Treatment

1. Identify and remove potential and actual barriers to access for services and treatment, e.g.,
 - address problems associated with obtaining consent from parents, guardians, the agency or the court for testing and treatment services;
 - address transportation needs;
 - assist families, caregivers, and social workers in navigating managed care;
 - establish protocols for 24-hour access;
 - locate providers near where children live.
2. Decide how children will have access to a medical home, e.g., through a community-based provider network, a specific community-based clinic, or a foster care clinic. Clearly define procedures for obtaining a primary care physician (PCP). Arrange for children to receive all of their health care services through this medical home, even when their placements change.

3. Assess and then strengthen, as needed, the provider network and service array that is available to meet the needs of children in foster care.
4. Promote direct access to specialty health care, e.g., establish relationships with specialty care providers through hospitals, medical centers, or health care coordinators. Allow PCPs to refer directly to specialty providers without prior authorization.

■ Management of Health Care Data and Information

1. Use creative strategies to gather initial health history information from families at the time of placement, e.g., a simple list to remind social workers of needed baseline information; having nurses talk with parents at the custody hearing.
2. Establish a system for gathering and recording needed health care information on children and their families and for sharing it with all involved persons. Sites used a number of different strategies for this such as:
 - manual or electronic “health passports”;
 - standardized medical forms;
 - computerized management information systems and Internet-based systems.
3. Create incentives for completing and using whatever data management system the community/state has selected. E.g.:
 - fiscal incentives, training and support for those who complete the forms/passports;
 - inviting feedback from the users on how to improve the system.
4. Commit resources to aggregate the data obtained on each child. Due to limited

To ensure a child’s safety and well-being, and to enhance his/her opportunity for a permanent placement, parents, caregivers, agencies, courts, schools, and health care providers must have a clear understanding of the child’s health care history and needs, as well as the services and supports required to meet those needs.

resources, few sites were doing this; however, they stressed the value of aggregate data in system planning—to determine the emerging health issues for children in foster care, service gaps, and resource needs.

■ Coordination of Care

1. Create an organizational structure for providing health care coordination for all children in foster care. Designate specific persons or a specific unit to carry this responsibility. (Nurses, medical case managers, and primary care practitioners often fill this role.)
2. Explore the possibility of using public health nurses, located at the child welfare agency, as care coordinators; as consultants to social workers, courts, parents and caregivers; and as liaisons between child welfare staff and health care providers.
3. Create a health care plan for every child in foster care. Health care coordination and management is the key for integrating health care services and social services. It can be used to incorporate a child’s health plan in the permanency plan and to share the health plan at court hearings and case reviews
4. Integrate primary health care, developmental and behavioral health services for each child.

■ Collaboration Among Systems

1. Child welfare agencies need to reach out to the health care system, the courts and other child-serving agencies and organizations to develop a comprehensive approach to meeting health and mental health needs of the children and families it serves. Many of the services that children in foster care need are not available from the child welfare agency. To improve access, availability and quality of services requires a cross-system approach.
2. Formalize collaborative efforts through interagency agreements, shared funding, and a collaborative governance structure.

3. Create specific mechanisms for communication, both formally and informally, e.g., specified liaisons between agencies. Ensure that communication occurs at all levels—social workers with families, as well as cross-system direct service staff, managers, administrators, and policy makers.
4. Consider locating health care professionals in child welfare offices. Direct communication is essential, and sharing office space enhances this.
5. Include all parties, especially families and the community, in these collaborative efforts and discussions. Address the issues they raise, e.g., respondents in a few sites noted that the health passport and the systems for comprehensive assessments would have been more effective if families, providers, and social workers had been involved in their development.
6. Top level commitment to change is essential. Share the leadership of collaborative efforts so that all involved agencies will “own” the initiative and make an equal commitment to its success.
7. Make concerted efforts to involve the courts so that they will be knowledgeable about health care issues and call attention to the health plan at each court hearing.
4. Develop non-threatening strategies to invite families to provide child and family health history information.
5. Focus on the entire family’s needs for health care, mental health, and substance abuse services.
6. Offer support services and in-home training for birth, foster, and adoptive parents and relative caretakers to enable them to meet the special health care needs of children in their homes.
7. Ensure that all health information about a child is shared with families when children are placed with them. This includes when returning children to their own homes or placing them with another permanent family.
8. Family expertise helps pinpoint needed services and identify what strategies work best. Invite parents to participate in efforts to improve health care services at the system

■ Family Participation

1. If there are no child safety issues that preclude families from being directly involved with their children, include birth parents in **all** aspects of a child’s health care.
2. Examine and change any existing agency policies and practices that might exclude or deter families from being involved in their child’s health care. Develop organizational policies and principles that promote family participation and involvement. Design health clinics to be accessible and family friendly.
3. Provide families with a list of ways they can be involved in their child’s health care (see **side bar**).

For Parents of Children in Foster Care: *How You Can Be Involved in Your Child’s Health Care*

- Explain to the agency your child’s health care needs and history, and also your family’s medical history.
- Share information with the social worker and health care providers about how your culture views health and illness.
- Request a comprehensive health exam for your child and participate in the process.
- Ask a medical person to discuss the results with you.
- Work with the agency to develop a health plan for your child.
- Attend medical appointments with your child.
- Discuss with the worker any special training and support services that will help you care for your child at home.
- Request and participate in treatment and services that you need for yourself.
- When your child is ready to come home, ask for information about Medicaid and the Child Health Insurance Program.

level by responding to surveys, participating in focus groups, serving on advisory committees, and acting as co-trainers.

■ Attention to Cultural Issues

1. Encourage family members to share information about their cultural traditions, values or practices related to health care and illness. Respect their preferences, and reflect this by adapting assessment and service delivery as much as is possible.
2. Hire health care staff and recruit health care providers who reflect the diversity of the community served and develop a mechanism for locating providers of a particular culture when needed (e.g., provider profiling).
3. Translate written materials related to health care into the child and family's primary language, e.g., the health care passport, reports of exam results.
4. Establish mechanisms to communicate with families in their primary language, e.g., hire trained medical interpreters.
5. Use assessment instruments that are appropriate for the culture of the child being assessed.
6. Establish clinics or provider networks in neighborhoods where children live.

■ Monitoring and Evaluation

This study describes features of promising approaches that states are implementing. It does not formally evaluate any of the approaches. There is need for more research (both by individual approaches and nationally) on the most effective strategies and interventions for this population of children and their families. It is important to have a clear accounting of the costs and benefits of each approach. Therefore, our first recommendation relates to conducting such evaluations.

1. Very few sites were conducting program and outcome evaluations due to lack of resources. A first step for each community or state is to determine the purpose and benefits of an evaluation of its health care

system for children in foster care; determine how the results of such an evaluation will be used; and commit the resources to conduct the evaluation.

2. Consider using public health nurses to monitor quality and provide support services for providers. This was being done by several of the sites that were interviewed.
3. Aggregate the data and information obtained on individual children to evaluate service needs and program outcomes (see management of data above).
4. Include **all** stakeholders in consumer satisfaction surveys.

■ Training and Education

1. Teach stakeholders how to use and work within the program or approach itself, ensuring that they understand how it operates.
2. Institutionalize training about health care issues for foster parents and for social workers by including it in orientation, core training and ongoing in-service sessions. Use foster parents and birth parents as co-trainers.
3. Provide individualized training for families and caregivers in their own homes when important for addressing the special conditions and needs of a child they are caring for.
4. Conduct cross-system training among the child welfare, health/mental health, and court systems. Special training for health care providers should address the topics of child abuse and neglect, foster care, child development, the policies and structure of the child welfare system, and the role of the courts. Training for child welfare and court staff should focus on special health care issues.

■ Funding Strategies

1. Explore all the potential uses of Medicaid as reimbursement for different aspects of the health care system, including

administration, case management/care coordination and direct services.

2. “Blend” or “braid” funds from multiple sources to cover costs not reimbursed by Medicaid.
3. Offer fiscal incentives to create services for children with special needs (e.g., enhanced per diem rates) and to encourage providers to participate.
4. Commit enough funds to the approach to adequately cover administrative costs and direct service costs.
5. Seek resources from multiple sources to fund the approach. The approaches in this study listed 20 different funding sources for their activities.

■ Designing Managed Care to Fit the Needs of Children in the Foster Care System

1. If the opportunity to participate in planning and designing the state and/or county managed care system still exists, child welfare stakeholders should be actively involved in that process.
2. If the managed care system is already in place, there are a number of ways to influence implementation of the existing system to ensure that the needs of children and families in the child welfare system will be met:
 - offer to train MCOs and providers to familiarize them with how the child welfare system works and the service needs of the children and families in the system;
 - train child welfare staff and families about how the managed care system works so that they can make appropriate decisions and secure needed services.
3. Create and institutionalize problem-solving mechanisms to address individual and system level issues, e.g.,
 - assign one or more persons to a special unit charged with assisting families and social workers in navigating the managed care system;
 - appoint clinical liaisons and/or special needs coordinators;
 - conduct regular cross-system (e.g., MCO, child welfare, health, mental health) management meetings.
4. If the state provides the option to include children in foster care in the managed care system, or to disenroll them when they enter care, carefully consider the advantages and disadvantages of both options.

Use these mechanisms to address issues such as:

- identifying service gaps and problems;
- clarifying payment responsibilities;
- adapting authorization and utilization review processes, and medical necessity criteria to the needs of children and families served by child welfare;
- expanding the service array and provider capacity;
- ensuring consistent care when children change placements;
- providing services for family members as well as children in foster care.

4. If the state provides the option to include children in foster care in the managed care system, or to disenroll them when they enter care, carefully consider the advantages and disadvantages of both options.

Overarching Policy and Practice Recommendations

Cross-cutting Recommendations

By articulating the comprehensive framework, this study has presented 11 components of a system for enhancing the health and well-being of children in foster care and has made recommendations, based on advice from the study respondents, within each of those components. The following three recommendations are cross-cutting and apply to the implementation of all of the components.

1. Create a **system** to actualize the recommendations and strategies.

Implementing new policies cannot be left to individual workers or a few enthusiastic supporters. A **system** implies having the organizational **structure** in place, the **resources** available, and a **process** to

implement the strategy. For example, it is not enough to pass a law that all children who enter foster care shall receive comprehensive assessments. There must be a structure in place to identify children as they come into care; there must be resources available to provide comprehensive assessments; and there must be multiple processes set up to gather background information, to schedule appointments, to transport children to the assessment, to share the findings of the assessment with all the appropriate people, and to monitor whether the assessment recommendations were implemented.

2. Implement improvements in health care services in all phases of the child/family's involvement with the child welfare system. This includes:

- before entry into the foster care system—to strengthen the possibility that the child can remain safely at home;
- at the point of entry when health history information, screening, and a comprehensive assessment are very important;
- during the time a child is in care—to assure that health care needs are met;
- during the transition out of foster care—to prepare the child or adolescent for a more permanent placement;
- after leaving foster care—to sustain any gains that have been made and to ensure ongoing continuity of care.

3. Build partnerships among local, state, and federal governments to enhance health care services and outcomes for children in foster care. Examine and clarify roles related to:

- committing to a vision;
- providing or creating the resources;
- reducing barriers in existing policies;
- developing new policy;
- creating incentives;
- implementing the changes.

Analyzing and Addressing Service Gaps

At the end of Chapter 4, we identified issues that are important to providing comprehensive health care for children in foster care but that represent ongoing challenges for, or are missing from, most of the 73 programs and sites that are part of this study's sample. They include:

- providing appropriate health care services for adolescents;
- strengthening participation by birth families and kinship care providers;
- providing mental health services for children with mild to moderate mental health needs;
- providing dental care;
- meeting a child's health care needs at transition points;
- focusing on appropriate health care services for children of color.

It is not possible from this study to conclude that these issues are not being addressed in states, communities, and individual programs that are not part of the study sample. However, it is essential for states and communities that are undertaking an effort to better meet the health care needs of children in foster care to consider including them in their planning efforts.

APPENDIX A

Contact Information for Each Site Example

■ Arkansas

Project for Adolescent and Child Evaluations

Susan S. Scott, M.S., CCC-SLP
Department of Pediatrics
University of Arkansas for Medical Sciences
1221 Bishop Street
Little Rock, AR 72202
Phone: (501) 320-7910
ScottSusanS@uams.edu

■ California

Pediatric Training for Juvenile Court Judges and Social Workers

Marcia C. Britton, M.D.
Child Health and Disability Prevention Program
Sacramento County Department of Health and
Human Services
9333 Tech Center Drive, Suite 100
Sacramento, CA 95826
Phone: (916) 875-7151
Fax: (916) 929-3883

Assessment and Consultation Team

Debbie LeFevre
Riverside County Department of Mental Health
9731 Magnolia Avenue
Riverside, CA 92503
Phone: (909) 358-6898
Fax: (909) 687-5819

Rx for Kids

Lois Manning
Ventura County Public Health
3147 Loma Vista Road
Ventura, California 93003
Phone: (805) 677-5202
Fax: (677-5223
lois.manning@mail.co.ventura.ca.us

Child Health and Disability Prevention Foster Care Program

Judith Quinn
Public Health Nurse
County of San Diego Health and Human Services
3851 Rosecrans, MS:P511H
San Diego, CA 92110
Phone: (619) 692-8489

Child Health and Disability Prevention Provider Unit

Phyllis Elkind
CHDP Coordinator
County of San Diego Health and Human Services
6950 Levant Street
San Diego, CA 92111
Phone: (619) 692-8810
Phyllis.Elkind@sdcounty.ca.gov

■ Illinois

HealthWorks of Illinois

Joe Anna Sullivan
Deputy Director
Illinois Department of Children
and Family Services
406 E. Monroe, Station 222
Springfield, IL 62704
Phone: (217) 557-2689 voice
jsullivan@idcfs.state.il.us

■ Montana

In-Care Network, Inc.

William F. Snell
Executive Director
2906 2nd Avenue, North, Suite 316
Billings, MT 59101
Phone: (406) 259-9616
wsnell@incarenetwork.com

■ New York

Foster Care Clinic and Mount Sinai Medical Center Collaboration

Beverly A. Colon
The Children's Aid Society
150 East 45th Street
New York, NY 10017
Phone: (212) 949-4958
beverlyc@childrensaidsociety.org

Family Healthcare Network

Luis Medina
Executive Director
St. Christopher's Inc.
71 Broadway
Dobbs Ferry, NY 10522
Phone: (914) 693-6608
Fax: (914) 693-3462

Monroe County Foster Care Pediatrics

Moira Szilagyi, M.D., Ph.D.
Medical Director
111 Westfall Rd.
Rochester, NY 14620
Phone: (716) 274-6927
Fax: (716) 292-3942
mszilagyi@monroecounty.gov

Westchester Institute for Human Development Family Program

Wendy Breitner
Cedarwood Hall, WCMC
Valhalla, NY 10595
Phone: (914) 493-8197
Fax: (914) 493-1023
Email: wbreitner@aol.com

The Permanent Judicial Commission on Justice for Children

Elysa Gordon
140 Grand Street, Suite 404
White Plains, NY
Phone: (914) 948-7581
Fax: (914) 948-7584

■ Pennsylvania

The Behavioral Health and Wellness Support Center, Philadelphia Department of Human Services

Dr. Joseph Kuna
City of Philadelphia
Department of Human Services
1515 Arch St.
Philadelphia, PA 19102
215/683-6018 voice
215/683-6023 fax
Joseph.E.Kuna@phila.gov

The Managed Care Unit, Philadelphia Department of Human Services

Thomas Mudrick, LSW
1515 Arch Street, Seventh Floor
Philadelphia, PA 19102
Phone: (215) 683-6175
Fax: (215) 683-6265
thomas.mudrick@phila.gov

■ Utah

Fostering Healthy Children

Chris Chytraus, RN
Program Manager, Fostering Healthy Children
Utah Department of Health
Division of Community and Family Health Services,
Children with Special Health Care Needs Bureau
44 North Medical Drive
Salt Lake City, UT 84114-4657
Phone: (801) 584-8502
Fax: (801) 584-8488
cchytrau@doh.state.ut.us

■ Virginia

Parent Educational Advocacy Training Center Caring Communities for Foster Care

Cathy Healy
Project Coordinator
Parent Educational Advocacy Training Center
6320 Augusta Drive, 12th Floor
Springfield, VA 22150
Phone: (703) 923-0010
Fax: (703) 923-0030
Email: partners@peatc.org

APPENDIX B

Compendium of Approaches Participating in Telephone Interviews

NOTE: Individuals from all of the approaches listed below in this compendium participated in telephone interviews with project staff. Contact information is provided in Appendix A for the approaches in this compendium that also are described in the narrative section of this document.

The project continued to gather information on additional approaches, after the completion of telephone interviews. Some of these additional approaches are referenced in the narrative section of the report, but they are not listed in this compendium.

LOCATION	APPROACH NAME
AK (Anchorage)	Health Passport Model
AR (state)	Project for Adolescent and Child Evaluations (PACE)
AZ (Tuscon)	Casita de Salud
CA (Alameda County)	Services to Enhance Early Development (SEED)
CA (Contra Costa County)	Using Public Health Nurses in Foster Care
CA (Los Angeles County)	Using Public Health Nurses in Foster Care; Tracking Health Care Data
CA (Los Angeles)	King/Drew Medical Center/Department of Children and Family Services Children’s Hub
CA (Marin County)	Multidisciplinary Holistic Approach to Ensuring the Health Care Needs of Children in Foster Care
CA (Riverside County)	Assessment and Consultation Team (ACT)
CA (Sacramento County)	Sacramento County Foster Care Health Program
CA (San Bernardino County)	Rx 4 Kids
CA (San Diego County)	Child Health and Disability Prevention Foster Care Program
CA (San Diego)	Developmental Screening and Evaluation Project, Children’s Hospital of San Diego
CA (San Diego)	Center for Child Protection, Children’s Hospital of San Diego
CA (state)	CA Foster Children’s Health Project (Public Health Nurse Role)
CA (Ventura County)	Rx for Kids
CO (El Paso County)	Partnership for Health
CT (New London County)	Comprehensive Health Care, United Community and Family Services
CT (state)	Health Care Advocacy Services

LOCATION	APPROACH NAME
DC (city)	DC Kids
FL (District 8–Ft. Meyers/Naples)	Foster Child Enhancement Program
IL (state)	HealthWorks of Illinois
IN (Marion County)	Therapeutic Foster Care Program
IN (Marion County)	Intensive Family Reunification Project
IN (Marion County)	Youth Emergency Services (YES), Indiana Behavioral Health Choices
IN (state)	Medical Passport for Children with Special Health Care Needs
KS (pilot in 2 urban counties)	CHERISH, University of Kansas Medical Center
KY (state)	Medical Passports
MA (state)	Multidisciplinary Assessment Teams (MDAT)
MA (state)	Special Kids/Special Care
MD (Baltimore)	Mental Health Screenings
MI (state)	Medical Passport
MN (consultation available nationwide)	U Special Kids, University of Minnesota
MO (Kansas City)	Medical Case Management
MT (statewide)	In-Care Network, Inc.
NC (Guilford County)	First Place
NH (state)	New Hampshire Foster Care Health Project
NJ (state)	Department of Youth and Family Services Child Health Program
NY (Monroe County)	Monroe County Foster Care Pediatrics
NY (New York City)	New Alternatives for Children, Inc.
NY (New York City)	St. Christopher’s, Inc. Family Healthcare Network
NY (New York City)	The Children’s Aid Society Foster Care Medical Clinic and Mount Sinai Medical Center Collaboration
NY (NYC and surrounding counties)	Abbott House
NY (Onondaga County)	ENHANCE Services for Children in Foster Care*
NY (state)	NY State Permanent Judicial Commission on Justice for Children
NY (state)	American Academy of Pediatrics, District II, Task Force on Health Care for Children in Foster Care
NY (Westchester County)	Westchester Institute for Human Development Family Program
NY (Westchester County)	Department of Social Services Pediatric Unit
OH (Lucas County)	Health Services Clinic
OH (Summit County)	Thomas W. Blazey Diagnostic Center

*Information obtained from written materials.

LOCATION	APPROACH NAME
OR (Portland)	Medical Foster Parent Program
PA (Philadelphia County)	Developing a Computerized Medical Database for Children in Out-of-Home Care
PA (Philadelphia)	Starting Young, Children’s Hospital of Philadelphia
PA (Philadelphia)	The Philadelphia Model, Managed Care Unit
PA (Pittsburgh)	REACH OUT, Children’s Hospital
PA (Westmoreland County)	Healthy Tomorrow, Mercy Children’s Medical Center
RI (state)	Early Intervention Surrogate Parents
RI (state)	Healthy Tomorrows
SC (Richland and Lexington Counties)	Medically Fragile Foster Care Program
TN (Knoxville)	Child and Family Clinic
TX (10 counties in Fort Worth area)	Permanency Achieved through Coordinated Efforts (PACE) Project, Lena Pope Home
TX (Austin)	Center for Adolescent Health, People’s Community Clinic
TX (Region 3–Dallas-Fort Worth area)	Children with Disabilities Program
UT (Salt Lake City)	South Main Foster Clinic, University of Utah
UT (state)	Fostering Healthy Children
VA (Charlottesville, Albemarle Co., Central VA)	Teen Health Center (THC), University of Virginia
VA (Fairfax County)	Caring Communities for Foster Children, Parent Educational Advocacy Training Center (PEATC)
VT (state)	Fostering Healthy Families
WA (Region 4–King County)	FAS Photo Screening Project
WA (state)	Foster Care Passport Program
WA (state)	Foster Care Assessment Program (FCAP)
WI (Milwaukee)	Foster Care Health Program of the Child Protection Center
WV (Region IV)	Foster Care Pilot Project

APPENDIX C

Advisory Panel Members

- Mary Lee Allen
- William Arroyo
- Gary Blau
- Suzanne Bronheim
- Patsy Buida
- Valerie Burrell-Muhammad
- Robin Chernoff
- Irene Clements
- Grady Dale
- Madelyn Freundlich
- Barbara Glasser
- Sybil Goldman
- Tawara Goode
- Vivian Jackson
- Neal Kaufman
- Susan Kimmerly
- Ursala Krieger
- Gabriel Landry
- Anita Marshall
- Charlotte McCullough
- Laura Oliven
- Carolyn Orf
- Trina Osher
- Cathy Overbagh
- Brenda Petersen
- Sheila Pires
- Roy Praschil
- Cheryl Ransom
- Joanne Rawlings-Sekunda
- Margo Rosenbach
- Barbara Rowe
- Rolando Santiago
- Phyllis Stubbs-Wynn
- Gretchen Test
- Alexy Yoffie
- Audrey Yowell

