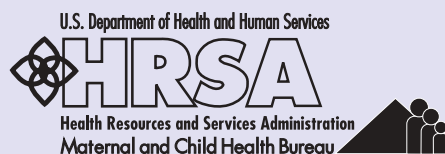**MEETING THE**

*H*ealth Care Needs of Children in the Foster Care System

STRATEGIES FOR IMPLEMENTATION

Georgetown University
Child Development Center

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

Strategies for Implementation

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SEPTEMBER 2002

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.

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CHAPTER 1

Introduction

This document is one in a set of reports resulting from a three-year study conducted by the Georgetown University Child Development Center to identify and describe promising approaches for meeting the health care needs of children in the foster care system. The study was funded primarily by the federal Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB) and supported in part by the Children's Bureau, Administration for Children and Families (ACF). Identification of these approaches was part of a larger effort of the *Public-Private Partnership for the Health of Children in Out-of-Home Care*[1] to improve and promote the health of children in foster care and their families.

Methodology for the Study

In this study, the term health care was utilized to encompass services and strategies for meeting children's physical, mental, emotional, developmental and dental health needs. A national search was conducted to solicit nominations for promising approaches being implemented in states and communities around the country to address the health care needs of children in the foster care system. Following this search, telephone interviews were conducted with key informants from 73 nominated sites. Nine site visits were subsequently conducted to obtain in-depth information from a range of stakeholders (e.g., child welfare administrators and caseworkers, health and mental health clinicians and administrators, birth parents and foster parents). A summary of key findings from the study, based on information collected during the telephone interviews and site visits, is available in a separate document—*Meeting the Health Care Needs of Children in the Foster Care System: Summary of State and Community Efforts*.[2]

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[1] The Public-Private Partnership is a group formed by a subcommittee of the MCHB-ACF Technical Advisory Group (TAG). The TAG was first convened in 1995 to explore efforts to enhance the health and well-being of America's children.

[2] Documents mentioned here are available in hard copy from the Georgetown University Child Development Center, or via the web at http://gucdc.georgetown.edu/foster.html

Based on data from the telephone interviews, a review of existing health care standards for children in foster care,[3,4] and input from this project's advisory panel, a framework of "critical components" that make up a comprehensive system for meeting the health care needs of children in the foster care system was developed. These components (described more fully in the document *Framework for a Comprehensive Approach: Critical Components*) include:

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/Education

10. Funding Strategies

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

Many of the states and communities identified in this study were implementing promising approaches around one or more of the critical components listed above. However, the project advisory committee and staff recognized that no single site in the study was likely to demonstrate competence in every one of these component areas. Thus, in selecting the nine sites to visit, we chose sites that together as a group would provide information about promising approaches for addressing the critical components. In particular, we focused on the first four components of the framework in selecting the sites—initial screening and comprehensive health assessment, access to health care services and treatment (physical,

mental health, developmental, dental), management of health care data and information, and coordination of care. Any of these four components can serve as the basis for a major initiative aimed at improving health care services for children in the foster care system. We considered the other seven components to be cross-cutting, that is, they should be addressed in some way as part of any approach that is implemented. Therefore, we inquired about each of them during the site visit interviews. Sites were also selected to represent a range of geographic locations, lead agency types, service areas, and populations served. Site visits were conducted during 2000 to obtain in-depth information on the following programs:

- **Project for Adolescent and Child Evaluations,** State of Arkansas

- **HealthWorks of Cook County,** Cook County, Illinois

- **HealthWorks of Illinois,** State of Illinois

- **Foster Care Pediatrics,** Monroe County, New York

- **Child Health and Disability Prevention (CHDP) Foster Care Program,** San Diego County, California

- **Assessment and Consultation Team,** Riverside County, California

- **In-Care Network,** Billings, Montana

- **The Children's Aid Society,** New York City

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

Purpose of this Document

In this report, designed to serve as a companion to the *Summary of State and Community Efforts,* we have sought to provide readers with detailed information and examples of the range of approaches states and communities are implementing to address the

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[3] Child Welfare League of America. *Standards for Health Care Services for Children in Out of Home Care.* Washington, DC: CWLA, Inc., 1988.

[4] American Academy of Pediatrics. "Health Care of Children in Foster Care." *Pediatrics* 93 (1994): 335-338.

health care needs of children in the foster care system. Additionally, the report is designed to serve as a tool for states and communities interested in creating or improving their own systems of health care provision. For example, the reader may be interested in learning about various models that exist for addressing a particular component of the comprehensive system described above.

The examples presented in the document are drawn in large part from information collected during the nine site visits, and supplemented by information from the telephone interviews. The document is by no means exhaustive in terms of its presentation of examples from the field; many other states and communities are working on initiatives similar to the ones described.

It should also be noted that because most of the approaches identified in this study have not been formally evaluated, research is still needed to compare the effectiveness of different models of service delivery. Specifically, as Simms et al. point out, "there have been no comparisons of the impact of these various approaches on health service utilization patterns, health status indicators of children, or costs."[5] In our presentation of various approaches, we therefore do not consider any one to be "right" or "wrong." Rather, we hope that this document will provide a range of ideas for states and communities to consider in their efforts to address comprehensively the health care needs of children served by the foster care system.

Organization of the Document

Based on our method for site visit selection, the chapters in this document are organized around the first four components of the comprehensive framework. The remaining seven cross-cutting components are addressed wherever possible throughout the document. For example, we describe the *funding strategies*

for various approaches, or discuss *family participation* by presenting examples of how families are included in assessment, service delivery, or health care coordination efforts. Similarly, many of the approaches profiled involve formal *collaboration across systems*.

One deviation from the comprehensive framework is our presentation of approaches geared specifically toward addressing *developmental* or *mental health* concerns in a separate chapter. This was done merely to highlight approaches that provide a continuum of screening, assessment and treatment services in these areas.

The remainder of the document is organized as follows:

Chapter 2: Initial Screening and Comprehensive Health Assessment

Chapter 3: Access to Health Care Services and Treatment

Chapter 4: Developmental and Mental Health Screening, Assessment, Services and Treatment

Chapter 5: Management of Health Care Data and Information

Chapter 6: Coordination of Care

In each chapter, we identify "Strategies and Approaches" that have been developed to address critical component being discussed. We also provide examples of these different types of approaches. Finally, in each chapter, we present specific "Topics for Discussion" that communities can utilize as part of their planning efforts.

Readers who are interested in more information about the approaches described in this document can obtain printed copies of detailed site visit reports and fact sheets on individual approaches from the Georgetown University Child Development Center. Documents are also available for download via the web at http://gucdc.georgetown.edu/foster.html in PDF format.

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5. Simms, Mark D., Howard Dubowitz, and Moira A. Szilagyi. "Health Care Needs of Children in the Foster Care System." *Pediatrics* 106 (2000): 909-918.

CHAPTER 2

Initial Screening and Comprehensive Health Assessment

Discussed in this Chapter

Strategies that states and communities are implementing to:

• Develop systems for conducting initial health screenings when children first enter care

• Develop systems for conducting comprehensive health assessments shortly after placement and at other points during a child's stay in out-of-home care

In this study, we defined the critical component of *Initial Screening and Comprehensive Health Assessment* as follows:

An initial health screening is provided for all children as they enter foster care. The screening is used to identify health problems that require immediate attention. Comprehensive 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 placement.

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 (more extensive than initial screenings) 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.[6]

This component reflects standards of health care for children in foster care developed by the American Academy of Pediatrics[7] and the Child Welfare League of America,[8] which recommend that children entering the foster care system receive **both** an initial health screen and a comprehensive assessment. However, one of the biggest challenges for states and communities has been figuring out how to create a **system** to ensure that this happens for every child entering care. In the next sections, we present examples of some systematic approaches for providing screenings and assessments.

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[6] Approaches that have been developed specifically to conduct screenings and assessments to address children's developmental or emotional strengths and needs are discussed in Chapter 4.

[7] American Academy of Pediatrics. "Health Care of Children in Foster Care." *Pediatrics* 93 (1994): 335-338.

[8] Child Welfare League of America. *Standards for Health Care Services for Children in Out of Home Care*. Washington, DC: CWLA, Inc., 1988.

Strategies and Approaches

Respondents in this study identified several different mechanisms for ensuring that children entering foster care receive initial screenings and comprehensive health assessments. They include:

- Formal agreements with hospital emergency rooms for conducting initial screenings;
- Screenings and assessments conducted in clinic settings created specifically for children entering foster care;
- Interdisciplinary assessment teams; and
- Use of EPSDT[9] providers and community-based provider networks.

In the section below, we provide examples from the study of each of these different strategies.

■ Formal agreements with hospital emergency rooms to conduct initial screenings

HealthWorks of Illinois
Cook County, Illinois and State of Illinois

HealthWorks is a comprehensive health care system implemented by the Illinois Department of Children and Family Services (DCFS) to improve the health status of children in the agency's care utilizing a community-based approach. In all counties outside of Cook County (Chicago), HealthWorks is implemented through local health departments that serve as lead agencies. In the Chicago area, DCFS has contracted with the Healthcare Consortium of Illinois, a community-based integrated health and human service organization, to function as the lead agency serving children in Cook County.

One component of the HealthWorks approach is designed to ensure that all children receive an initial health screen within 24 hours of entry into DCFS custody, and preferably prior to placement in substitute care. The purpose of the initial health screen is to treat any acute

> ### Key Issues Related to Initial Screenings
>
> **Presumptive Medicaid eligibility**—Some states are utilizing this strategy to ensure that children can receive health care services (including screenings) immediately upon entering placement. For example, in Illinois, all children who enter placement are presumed eligible for Medicaid as a family of one and are given a temporary Medicaid card. Approximately 95% later become officially eligible for Medicaid. The Department of Child and Family Services covers the cost of initial screens that were conducted for any children found later to be ineligible for Medicaid.
>
> **Minimizing trauma to the child**—Children entering foster care are in the midst of a crisis. Thus, their comfort and state of mind should be considered as factors in selecting screening locations and procedures. Likewise, screening personnel must be sensitive to the child's situation, and utilize the screening as an opportunity to address how the child is coping with the crisis. Child Welfare League of America standards dictate that screenings should be conducted in the least traumatic way possible, and that "recognition must be given to the traumatic circumstances surrounding the child's entry into care."[10]

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 infections or communicable diseases, and provide the DCFS caseworker with medical information needed for making an appropriate placement decision for the child.

In Cook County, the lead agency has contracted primarily with hospital emergency rooms to provide initial health screens because they are available 24 hours a day and are located in many different communities. When a child enters care, the DCFS worker calls a 24-hour HealthLine to schedule a screening. The HealthLine operator contacts the nearest screening site to determine that they can serve the child immediately and then directs the worker to that site. Each screening site has

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[9] EPSDT is Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program.

[10] Child Welfare League of America. *Standards for Health Care Services for Children in Out of Home Care.*

agreed to screen children within one hour of their arrival. In exchange for this, they receive an enhanced rate for each screening that is completed. The call to the HealthLine is intended to reduce long waits by alerting the site that a child is coming and minimize the distance a child needs to be transported. Sometimes, if a nearby site is not able to screen the child within the hour, a worker may choose to go to a more distant hospital that can see the child immediately. In counties outside of the Chicago area, the DCFS worker takes the child to any provider who does initial health screens and who is listed in the area's HealthWorks provider handbook. ◆

■ Screening and assessment in clinic settings created specifically for children entering foster care

In this study, we spoke to individuals in nearly 20 communities that have established clinics that specialize in providing health care services to children in foster care. Some of these clinics were created to function as centralized assessment centers for children entering foster care. Others provide a full range of health care services including initial screening, comprehensive assessment, and routine pediatric care. Still others provide access to mental health, developmental, and dental services on site, as well. We discuss some of these clinics here; other examples are presented in Chapter 3.

Donner School Clinic
Sacramento County, California

In Sacramento, a former elementary school has been converted into a facility where social work staff and clinical staff are co-located. The Donner School—remodeled by the University of California Davis Medical Center (UCDMC)—houses a specialized foster care clinic and a "comfort care room" for children newly admitted to foster care. It is designed to serve as a child-centered facility that provides children with a safe haven during initial

screenings and comprehensive health exams. The comfort care room was created because of concern over poor conditions (e.g., children left sitting in hallways) at the county receiving center where children were taken after removal from their homes. In the comfort care room, children are assessed for injuries, fed, clothed and allowed to rest or play until they are picked up for placement. The clinic provides initial health screenings for children entering care to avoid having to transport them to emergency rooms. In addition, the clinic provides the 30-day comprehensive health assessments required for all children in foster care. The assessment includes a complete physical examination, dental assessment, developmental assessment, psychiatric evaluation, and nutritional evaluation. Children are re-assessed two months after the initial assessment, and then monitored by UCDMC every four to six months based on feedback from primary care providers, social workers and schools. Children continue to receive health care through UCDMC (at the Donner clinic or at a second satellite clinic) for the first 90 days of placement. Following this time period, the children may remain with UCDMC for care or be assigned to a provider in the community.

The Donner School project represents a collaborative effort (both in terms of staffing and funding) between the public child welfare agency, health department and a university-based medical center. Co-located at the clinic are child protective services social workers and intake workers, public health nurses, and pediatric faculty from UCDMC. Funding sources include EPSDT, county general funds, child protective services funds, UCDMC, the Victim Witness Program, and private donations. ◆

ENHANCE Services for Children in Foster Care[11]
Onondaga County, New York

ENHANCE is a comprehensive, multidisciplinary clinic for children in foster care that represents a collaboration between the State University of New York (SUNY)

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[11] Detailed information on this approach can be found in Blatt, D., et al. A Comprehensive, Multidisciplinary Approach to Providing Health Care for Children in Out-of-Home Care. *Child Welfare* 76 (1997): 331-349.

Upstate Medical Center and the Onondaga County Department of Social Services (DSS). Children entering foster care in the county receive both initial screenings and comprehensive assessments at the clinic. An initial visit typically occurs within one week of placement, and includes a physical examination, routine blood tests, and the opportunity for the foster parent to meet with a child psychologist to discuss any acute mental health needs. Prior to the initial visit, a DSS liaison to the clinic provides clinicians with a child's history, and clinic staff meet to review the background information. A comprehensive visit is scheduled one month after the initial visit. A complete physical examination is conducted, including hearing and vision screens. During the comprehensive visit, preschool and school-age children receive a psychological assessment. Children up to 18 months of age receive a developmental screening in the foster home conducted by a clinical nurse specialist.

ENHANCE staff seek to involve foster parents in all aspects of a child's care. When possible, biological parents are interviewed as part of the child's psychological assessment. When children are leaving the foster care system, a discharge visit is scheduled with the child's guardian to ensure that all health information is transferred and to coordinate the transition to new providers. Families may elect to have a child continue to receive care through Upstate Medical Center after they exit foster care. ◆

Thomas W. Blazey Diagnostic Center
Summit County, Ohio

The Thomas W. Blazey Diagnostic Center opened in 1995 to serve as a one-stop clinic providing medical, dental and psychosocial services for children in the care of Summit County Children Services. The center was designed to be child and family friendly, including furnishings designed to minimize trauma for children entering care. The facility has separate areas for medical and dental services, separate waiting rooms for sick children and well children, and an area for

conducting family assessments. When children are first removed from their homes, they receive a complete physical examination at the center. Because the county has a preference for kinship care, a family assessment is conducted for any child who has been in care for at least two weeks, in order to determine the best placement for the child. Upon any placement change, or prior to discharge from agency care, children receive a follow-up assessment to provide both the family and subsequent medical providers with current health information. ◆

■ Interdisciplinary assessment teams

Project for Adolescent and Child Evaluations
State of Arkansas

The Project for Adolescent and Child Evaluations (PACE) is a collaborative effort between the Division of Child and Family Services (DCFS) and the University of Arkansas for Medical Sciences (UAMS), where PACE is housed. The project was developed to address an issue that many rural states face, that of having most health care resources located in a few urban areas of the state. In particular, the project seeks to remedy barriers to the receipt of multidisciplinary, comprehensive health assessments. All children are expected to receive this assessment within 60 days of entering DCFS custody.

PACE has created a number of multidisciplinary assessment teams that rove the state to conduct comprehensive assessments at 16 different sites. These teams each consist of a developmental pediatrician, psychologist/psychological examiner, speech/language pathologist and an assistant. The 16 assessment sites were located strategically around the state, based on where children are coming into care. Assessment sites are generally existing health facilities such as clinics, hospitals, health centers, or schools. The traveling assessment teams transport all of their equipment with them as they move from site to site. Vans were purchased to facilitate the teams' travel.

The Division of Child and Family Services notifies PACE of new children entering care for whom assessments need to be scheduled. Each child entering care receives a full team evaluation consisting of hearing and vision screenings, cognitive, academic, and behavioral/emotional assessments, a medical/developmental evaluation, speech and language assessment, and feeding assessment when appropriate. After an evaluation is completed, team members (including a DCFS representative) discuss their findings and form a complete list of impressions and recommendations. A completed evaluation report is submitted to DCFS within two weeks of the appointment. Evaluations and recommendations are individualized, based on input from multiple sources. School and medical records are requested to facilitate the most appropriate recommendations. DCFS has assigned health service workers in county offices to interface with the PACE project and coordinate follow-up care. The PACE project is funded by a contract between the University of Arkansas for Medical Sciences and DCFS, with Medicaid reimbursement for clinical services. ◆

Foster Care Assessment Program
State of Washington
The Foster Care Assessment Program in Washington State is a service operated under contract with the Department of Social and Health Services (DSHS), Children's Administration to serve children and youth who have remained in foster care without a permanency plan accomplished.
The program is administered by Harborview Center for Sexual Assault and Traumatic Stress, in collaboration with the Children's Protection Program at Children's Hospital and Regional Medical Center. Every DSHS region in the state has access to Foster Care Assessment Program services in at least one community. The program's objectives are: to ensure that the physical and emotional health, developmental status, and educational adjustment of children in state custody have been assessed and any significant needs addressed; and to identify and help resolve

obstacles to permanency planning. Children and youth served by the program may include children for whom permanency planning has been stalled because no permanent family resource could be identified or developed for the child; children with physical, emotional or mental health needs that have created barriers to permanency planning; and children with an incomplete diagnostic picture for whom additional assessment could assist in permanency planning.

Referrals to the Foster Care Assessment Program come from child welfare agency social workers through a regional coordinator for the program. To carry out the assessment services in local communities, the Harborview Center contracts with hospital-based child abuse programs and community-based agencies in each region of the state to convene interdisciplinary teams of professionals. Each interdisciplinary team includes a diversity consultant to address the needs of families from diverse cultures. Children referred to the program receive a comprehensive physical, developmental, and emotional assessment. The assessment process also incorporates interviews with people involved in the child's life, a review of the child's medical records, and consultation with other professionals. Following the assessment, the interdisciplinary team produces a comprehensive report that includes a permanency assessment and conducts a meeting with the key people in the child's life to develop a short-term service plan for the child. Follow-up assistance is provided for a period of six months. ◆

Multidisciplinary Assessment Teams
Commonwealth of Massachusetts
The Massachusetts Department of Social Services (DSS) has created regional multidisciplinary teams throughout the state to provide comprehensive clinical assessments that will enable the Department to better understand a family's needs. Multidisciplinary Assessment Teams (MDATs) are convened by DSS area managers. Each area office employs its own method for prioritizing families who

might benefit from the services of the MDAT. It is the role of the DSS worker or supervisor to refer families to the team convener.

Membership on the multidisciplinary teams includes community providers with expertise

in a variety of disciplines including substance abuse, domestic violence, mental health, trauma, and pediatric medicine. In addition to these core professionals, various teams also involve other professionals such as education specialists, parent educators, family advocates, probation officers, and police officers. Team sizes range from 6 to 12 members. Family members are encouraged to attend team meetings.

MDATs do not simply review the existing paperwork on families. Instead, various team members will meet with family members during the assessment process to ensure that their interests and views are represented. One region implemented use of a School Observation Form to help teachers assess children's adjustment in the school environment. MDAT members collaborate to provide evaluations, recommend service plans, and link families to recommended services in the community. Each team has access to a budget of state dollars that function as flexible funds. These funds may be utilized to purchase services necessary to complete a comprehensive assessment that are not available through third party billing or DSS contracts. ◆

■ Use of EPSDT providers and community-based provider networks

Child Health and Disability Prevention (CHDP) Foster Care Program
San Diego County, CA

California's EPSDT program is known statewide as the Child Health and Disability Prevention (CHDP) program. The CHDP Foster Care Program is a part of California's broader CHDP program. With the support of federal Medicaid matching funds from EPSDT, public health nurses were hired to implement the CHDP Foster Care Program in San Diego County.

Children entering foster care in San Diego are expected to receive a CHDP exam within 30 days of placement. Caseworkers notify the foster parent about the exam requirement. A public health nurse from the CHDP Foster

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Key Issues Related to Comprehensive Assessments

Ensuring follow-up on recommendations— When significant resources are devoted to ensuring that children entering foster care receive comprehensive assessments, it is also critical to ensure that follow-up takes place on recommendations from the assessments.

For example, the **PACE** project in Arkansas tracks both the percentage of children receiving a comprehensive assessment within 60 days of entering care and the percentage of follow-up recommendations completed. This effort revealed that, for the most part, follow-up services were being received. However, in one county, child welfare workers were having difficulty ensuring completion of follow-up recommendations. As a result, the PACE project added a patient care coordinator to its team to assist the county in following up on service recommendations.

The **Starting Young Program** (described in Chapter 4), which provides multidisciplinary developmental evaluations for children up to 30 months of age, has added the services of a nurse medical care coordinator to its team. This role was created because of a finding that adherence to the multidisciplinary team's recommendations for additional evaluations and interventions was only 57%.

Striking a balance between assessments that are too cursory or too intensive— Comprehensive health assessments address multiple domains of a child's life (medical, emotional, behavioral, developmental). When comprehensive assessments are conducted for every child entering care, it is important to ensure that providers conduct thorough evaluations and that the assessment process does not become perfunctory or cursory. At the same time, it is important that assessments not be overly intensive or traumatic for the child. Consideration should be given to the value of assessments for identifying needed treatment or academic placement, costs, and the importance of individualizing the assessment process for each child.

What Should an EPSDT Visit Include?

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT requires states to provide Medicaid-eligible children with periodic screening, vision, dental, and hearing services. It also requires states to provide any medically necessary health services listed in the Medicaid statute whether or not such services are covered in the State plan.[12]

EPSDT examinations must include the following components:

- comprehensive health and developmental history, including assessment of both physical and mental health development;
- comprehensive unclothed physical exam;
- appropriate immunizations according to age and health history;
- laboratory tests including a lead toxicity screening;
- health education, including anticipatory guidance;
- vision, hearing, and dental screens.

Some states have negotiated enhanced reimbursement rates for EPSDT providers conducting assessments for children entering foster care based on an "extended first visit."

Care Program also sends a letter to the foster family and includes a CHDP provider list from which to select a provider to conduct the examination. There are approximately 230 CHDP providers in San Diego County, who are a specialized group of Medi-Cal (California's Medicaid program) providers. Following an exam, the provider is expected to submit the results back to the public health nurse using a standardized form (PM 160 form). The nurse then contacts the foster parent to discuss any health problems noted on the exam form, and works to ensure that recommended follow-up care is received.◆

HealthWorks of Illinois
Cook County, Illinois and State of Illinois

Children in Illinois are expected to receive a comprehensive health evaluation, based on EPSDT standards (see sidebar), within 21 days of their initial health screen. If possible, this exam is to be conducted by the child's primary care physician. In Cook County, the foster parent or substitute caregiver is given the number of the HealthLine to call as soon as the child is placed in order to select a physician and schedule the comprehensive health evaluation. The HealthLine operator informs the foster parent of available primary care physicians to choose from and then contacts the provider to schedule an appointment. Outside of Cook County, the foster parent contacts a primary care physician directly to make an appointment for the comprehensive health evaluation. Foster parents are given a HealthWorks Provider Handbook that lists physicians in their particular area. HealthWorks will also provide assistance to the foster parent if it is needed to locate a primary care physician. Foster parents may use their own physicians if the physician is already in the HealthWorks provider network. If the foster parent wishes to use a physician who is not in the HealthWorks network, she may do so temporarily (for up to 90 days) if the provider meets the qualifications required by HealthWorks. The provider will then be recruited to become a member of the HealthWorks provider network. Participating providers are required to use and complete all HealthWorks documentation (including the Health Passport) when they conduct a comprehensive evaluation, and, in turn, are reimbursed for the evaluation at an enhanced rate.◆

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[12] For more information, refer to http://cms.hhs.gov/medicaid/epsdt/default.asp

TOPICS FOR DISCUSSION

Questions to Consider in Developing an Approach for Conducting Initial Screenings and Comprehensive Health Assessments

The following questions are provided for states and communities to consider when planning or improving their approach for conducting initial screenings and comprehensive health assessments for children entering and already a part of the foster care system.

1. Policy Questions

☐ What timeframe will be established for conducting initial screenings? Comprehensive assessments?

☐ Will all children receive the "most comprehensive assessment," or just those for whom a triage approach indicates a need?

☐ Who will receive or have access to results of the assessment? How will confidentiality be ensured when these results are shared?

☐ What protocols for HIV testing will be established?

☐ Will children be re-assessed upon changes in placement or before reunification or adoption?

☐ Will there be provisions for providing screenings/assessments for children who move directly into kinship care?

2. Service Questions

☐ Where and when will screenings and assessments be conducted? Is the setting child-friendly and relaxed?

☐ Who will conduct screenings? Assessments?
  – If special teams are used for assessments who are not the same as children's ongoing providers, how will continuity of care be ensured?
  – If providers in the community are used, will they have special training on interviewing/evaluating children who have been sexually or physically abused?

☐ What components will be included as part of the comprehensive assessment? Will everything take place at one time, or on separate occasions? How can stress for the child be minimized?

☐ How will follow-up care based on results of the assessment be ensured?

3. Financing Questions

☐ How will the costs of screenings and assessments be covered?

☐ Is an enhanced Medicaid rate available to compensate providers for additional time spent conducting comprehensive assessments, completing required paperwork, etc.?

TOPICS FOR DISCUSSION *continued*

4. Information Questions

☐ How will providers conducting screenings/assessments be notified regarding children entering placement who need a screening/assessment?

☐ How will information about the child relevant to the assessment process be obtained from family members or other individuals knowledgeable about the child?

☐ Will previous medical records be obtained and reviewed prior to an assessment?

☐ Whose responsibility will it be to collect this information and convey it to those conducting the assessments?

☐ How will results of the assessment be shared among clinicians, caseworkers, family members, and other health care providers?

5. Family Participation Questions

☐ How/when/where will birth parents be approached to provide health history information about the child?

☐ How will birth and foster parents be involved in the assessment process? Will their own health or mental health needs be assessed?

☐ How will birth and foster families be provided with information/reports following comprehensive assessments?

☐ Who will assist families in understanding the health issues identified during the assessment?

6. Cultural Competence Questions

☐ Are the instruments/tools utilized in the assessment process culturally appropriate?

☐ Are practitioners conducting assessments aware of cultural biases in assessment instruments? Are they knowledgeable about the impact of linguistic and cultural patterns on test questions and results?

☐ Are interpreters or practitioners who speak different languages (including sign language) available?

Access to Health Care Services and Treatment

Discussed in this Chapter

Strategies that states and communities are implementing to:

• Remove barriers to accessing health care services and treatment

• Ensure that children in foster care have access to primary care services in a medical home

• Provide access to specialty medical care

In this study, we defined the critical component *Access to Health Care Services and Treatment* as follows:

> *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 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.[13] Family support services that enable caretakers to attend to a child's health care needs are also available.*

Respondents in the study identified a range of challenges they face in trying to ensure that all children in foster care have access to quality health care services and treatment. Some of the most frequently cited challenges included:

• low reimbursement rates for providers;

• lack of providers willing to accept Medicaid;

• limited number of providers in rural areas;

• barriers created by managed care systems;

• complexity of the health care needs of children in foster care;

• health care providers who are not adequately trained in the health care needs of children in the foster care system; and

• integrating physical health care and mental health care.

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[13] Approaches that have been developed specifically to provide services and treatment to address children's developmental and mental health needs are discussed in Chapter 4.

Across the entire study, mental health needs stood out consistently as being the most difficult to address in terms of obtaining appropriate services. Hence, we have chosen to discuss approaches to providing mental health services in a separate chapter devoted to that topic (see Chapter 4).

Strategies and Approaches

■ Removing barriers to accessing health care services and treatment

A number of communities have developed strategies designed specifically to address barriers that stand in the way of accessing care. Respondents described efforts in the following areas:

■ **Resolving the issue of consent**—Problems associated with obtaining consent for certain types of testing or treatment frequently cause delays in service delivery. Common issues include uncertainty around who has authority to consent for what, insufficient efforts made to contact birth parents, or birth parents who are unavailable to provide consent. Respondents in this study cited consent for early intervention services, mental health assessment, and prescription of psychotropic medications as being particularly problematic.

■ **Helping families to navigate Medicaid managed care systems**—When children in foster care are included as part of a managed care system, their caregivers often experience difficulty in choosing the best managed care plan, understanding preauthorization requirements, and accessing appropriate providers for both primary care and specialty care. It is very important that the system provide them access to someone who understands both the special needs of children in the child welfare system and how the managed care system operates.

■ **Strengthening provider networks**—In many areas, efforts must be made to increase the number of qualified providers willing to serve children in foster care. Some communities are offering enhanced supports or other incentives to attract providers to their networks. They may also incorporate quality assurance activities, and provide information and training for providers so that they may better address the needs of children in foster care.

■ Resolving the issue of consent

Healthy Children: A Guide for Parents and Guardians
A project of the First Judicial District of Pennsylvania

The First Judicial District of Pennsylvania has developed *Healthy Children: A Guide for Parents and Guardians*, a brochure that explains how parents and guardians can help to ensure that their children receive appropriate health care services while in court-ordered placement. The brochure identifies the types of consent forms parents/guardians may be asked to sign (e.g., release of records, consent for mental health evaluation and treatment), why these are important, and what will be done with the information. Consent forms have been created for various types of health care evaluations and services. These forms are discussed and signed during a mandatory pre-hearing conference with parents that takes place just before each adjudicatory hearing. ◆

Early Intervention Surrogate Parents
State of Rhode Island

In Rhode Island, the Early Intervention Surrogate Parents approach is utilized to expedite services for children eligible for Part C, Early Intervention (EI) services under the Individuals with Disabilities Education Act (IDEA). The approach addresses a barrier that existed for children in foster care due to regulations prohibiting the state from functioning as a child's "parent" for the purpose of consenting for EI evaluations and services. Children in the custody of the Department of Children, Youth and Families (DCYF) who have been referred for EI services are appointed a "surrogate parent" by the Rhode Island Department of Health if the birth parent indicates that she/he does not wish to

participate in the EI services or cannot be located. Both EI and DCYF staff are trained so that a timely appointment can be made in order to avoid unnecessary service delays. Often, surrogate parents are a child's foster parents, and they are afforded the same rights as birth parents by the EI program. Surrogate parents receive training through a parent-professional model to assist them in accessing EI services.◆

Developing a Consent Protocol
Monroe County, New York

In Monroe County, NY, children in foster care are viewed as the responsibility of the whole county, not just the Department of Social Services (DSS). Further, it is a statutory responsibility for the county to provide for the health and well-being of children in its care and custody. Hence, difficulties encountered in determining who had authority for various types of consent were addressed through a collaborative effort between representatives of both the Department of Health and DSS. This effort ultimately led to the development of a "consent protocol." The first aspect of the protocol involves having the child's birth parent/legal guardian sign a general medical consent at the time of placement. On this form the guardian consents to health care for preventive, acute and ongoing chronic medical illnesses, mental health evaluation, dental care, and developmental evaluations and services. The general medical consent does not cover consent for psychotropic medications. A statement on the form indicates that a separate consent will be needed in that event. When informed consent is required for anything not covered on the general form, the following process was put into place: a certified return receipt letter is mailed to the legal guardian after phone and visit contact attempts have failed; a second letter must go out if the first is not answered; in the event that there is no response (a "reasonable" time frame has been defined), a foster care administrator has authority to sign the consent.

Work on the consent protocol has led the departments and attorneys to realize that they have a role in a) informing birth parents/legal guardians in detail about what they are signing b) providing for an alternative consent by DSS if the legal guardian is unavailable or uncooperative, since the county is responsible for the child's health and well-being while in custody, and c) clearly delineating for families that if they chose not to sign, the county has an alternative mechanism to provide the care their child may need.◆

■ Helping families to navigate Medicaid managed care systems

Health Care Advocacy Services
State of Connecticut

In Connecticut, virtually all children in foster care are enrolled in one of five managed care organizations (MCOs). Health Care Advocacy Services (HCAS) is a unit created to serve as a resource for caregivers of children in foster care who are enrolled in the MCOs. The HCAS staff includes five health care advocates (one per region) plus a program supervisor. The primary function of the health care advocate is to facilitate health care delivery to children in foster care by providing caretakers with training, technical assistance, support groups, and specific information about the MCO in which a child is enrolled. Although these services are typically provided to foster parents and residential providers, they are also available for children who are adopted or reunified with their biological families if they remain Medicaid eligible. In addition to providing assistance to caretakers, health care advocates also work closely with the MCOs to ensure that children receive the necessary health care for which they are covered.◆

Managed Care Unit
Philadelphia, Pennsylvania

The initiation of a managed care program for all Medicaid beneficiaries in the southeastern region of Pennsylvania created new barriers to health care for children in foster care and exacerbated some of the barriers that already existed. To ensure that the managed care system could accommodate the special

circumstances of children in substitute care and provide access to appropriate and necessary medical care, the Department of Human Services developed what is referred to as "The Philadelphia Model." In "The Philadelphia Model" a Managed Care Unit (MCU) was created to address the needs of children placed in foster care. The MCU is staffed by five social workers who are responsible for coordinating the physical health care services required by children in care, interfacing with the many stakeholders who have direct or indirect relationships with the children, mediating any problems which may arise, and advocating for appropriate benefits to assure continuity in physical health care. The MCU provides training for social workers, foster parents, attorneys, and county solicitors on how to navigate the managed care system, as well as training for managed care organizations on the child welfare system.◆

■ Strengthening provider networks

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

The Child Health and Disability Prevention (CHDP) Provider Unit is an office within the County of San Diego Health and Human Service Agency that offers support to the CHDP Foster Care Program. (CHDP is the name California uses for its EPSDT program.) The Provider Unit is staffed by public health nurses, and focuses on strengthening the provider network for children in foster care and other children served by the CHDP program. One of the major tasks of the Provider Unit is to ensure that sufficient numbers of qualified medical providers are available. There are approximately 230 CHDP providers in San Diego County, a specialized group of Medi-Cal providers who are qualified to perform CHDP exams. They are allowed to bill Medi-Cal for a wider than usual array of well-child services because of broader billing codes.

Nurses from the CHDP Provider Unit offer a number of supports to CHDP providers and monitor them for purposes of quality

assurance. The services and supports from the nurses are incentives for registering as a CHDP provider. These supports, in turn, strengthen the provider network that is available to children in foster care. All foster parents are provided with updated lists of CHDP providers in their area.

Some of the responsibilities of the public health nurses in the Provider Unit include:

- recruiting and certifying new providers;

- completing an initial site review for new providers and updating site reviews every three years;

- offering monthly orientations for new providers, in-service sessions for existing providers, and bulletins which include updates on health care issues, billing issues, and information on complying with required paperwork;

- reviewing and revising standards for providers annually, or as needed;

- monitoring providers for quality assurance; and

- serving as the liaison to Medi-Cal managed care plans.◆

■ Ensuring that children in foster care have access to primary care services in a medical home

The American Academy of Pediatrics has highlighted the importance to children in foster care of maintaining consistency in health services—a medical home—particularly in light of the transient nature of foster care placements. Several types of approaches have been developed by states and communities to deal with the problem of scattered and fragmented care, and to ensure that every child has a medical home. Three general approaches emerged in this study:

■ **Foster care clinics**—A number of communities have established clinics that specialize in providing health care services to children in foster care. Typically, these have grown out of collaborative relationships

> Children in foster care "should receive all of their health care services (routine preventive, acute illness, chronic illness) from a single health practitioner who will get to know them and with whom they can bond and in whom they can confide."[14]

between social service agencies, health departments, universities/medical schools, and hospitals. Some foster care clinics are co-located in the same building as the child welfare agency. Some private child welfare agencies, particularly in New York City and surrounding areas, also operate foster care clinics.

Potential benefits derived from having a foster care clinic include:

– improved care coordination and continuity of care while a child is in placement;

– medical staff specialized in foster care;

– a centralized location where medical records for all children in foster care are maintained;

– additional health-related services needed by children in foster care can be provided on-site (e.g., developmental screenings);

– the clinic serves as a resource for child welfare workers, the court system, and families about health care issues for children in out-of-home placement;

– the clinic can function as a training site for medical students, interns, etc. to learn about the needs of children served through the foster care system.

■ **Community-based clinics**—Community-based clinics are sometimes created or utilized to provide care similar to that of the foster care clinic. Generally, however, community-based clinics are located in neighborhoods where large numbers of children in foster care live, and the services provided are not limited to the foster care population. For example, some clinics may provide services to birth families, or to low-income families as well. Community-based

clinics have been established by both public and private child welfare agencies.

Potential benefits derived from establishing community-based clinics include:

– health care services can be made available to the entire family, including a child's birth family;

– continuity of care—children may continue to receive care through the clinic after leaving the foster care system;

– needs of the child and family can be viewed in the context of the community;

– it may be easier to link the family to other supportive services if the clinic is located near the child's home and school.

■ **Community-based provider networks and agencies**—As discussed earlier in this chapter, some communities have established special networks of providers or contracted with provider agencies to serve children in foster care. Providers in these networks must meet certain qualifications and accept certain additional responsibilities (e.g., completing additional paperwork, filling out health passports). Accountability mechanisms may be created to monitor provider agencies.

Potential benefits derived from utilizing community-based provider networks or agencies include:

– families have a choice of providers;

– families have access to providers located near their homes;

– other family members might be able to use the same providers;

– children might be able to use the same providers after leaving foster care;

– expansion of provider networks, or contracting with community-based agencies can increase access to culturally diverse providers;

– quality assurance mechanisms can be implemented when providers are part of a network.

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[14] Task Force on Health Care for Children in Foster Care. *Fostering Health: Health Care for Children in Foster Care.* Lake Success, NY: American Academy of Pediatrics, District II, NYS, 2001.

■ Foster care clinics

Foster Care Pediatrics
Monroe County, New York

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, New York. Foster Care Pediatrics operates under the auspices of Monroe County Department of Health in collaboration with Monroe County Department of Social Services. The clinic is co-located in a building shared by the Department of Health and the Department of Social Services. Services provided at the clinic are funded primarily through Medicaid, with some financial support provided by the Department of Health. The medical team is composed of pediatricians, pediatric nurse practitioners, nurses, a social worker, and clerical staff. The program averages 4,000 visits per year.

In addition to primary care services, the clinic offers bimonthly developmental screenings conducted by a developmental pediatrician, on-site assessment of possible sexual or physical abuse, and a careful monitoring of children receiving psychotropic medications. Clinic staff ensure that comprehensive developmental, mental health, and other consultations are obtained from the community and tertiary care centers. They also ensure that foster families, birth parents, caseworkers, law guardians, county attorneys, and judges have access to the health care information needed for long-term permanency planning. Foster Care Pediatrics provides night and weekend coverage through contracts with a group of nurses who provide triage services and assistance to families.

Since its inception, Foster Care Pediatrics has reduced the rates of hospitalizations and unnecessary emergency room visits for children in foster care. Immunization rates have risen to 95%, having been less than 50% before the program, and placement stability for children with complex medical needs has improved.◆

■ Community-based clinics

Partnership for Health
El Paso County, Colorado

The Partnership for Health is a collaborative effort between the El Paso County Department of Human Services (DHS) and Community Health Center, which operates two clinics in the county. The collaboration established the Community Health Center as the preferred medical and dental provider for children in foster care and their families. Community Health Center is a Federally Qualified Health Care Provider. As the designated medical and dental provider of choice for children in foster care in the county, the the agency provides health screening and assessment, primary care, dental care, developmental services, and referral to other providers for children with special health care needs. Because the clinics provide care for both children and adults, with or without insurance, children in foster care and their birth families have continued access to the clinics even after children return home. In addition, children can continue with the same medical and dental providers when and if placement changes occur.◆

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

St. Christopher's, Inc. is a voluntary, not-for-profit agency in New York City that includes foster care among its array of services. In line with St. Christopher's goal of strengthening and reuniting families, the agency has identified ways to ensure that it delivers comprehensive health care (including medical, mental health, and substance abuse treatment) to families in the communities in which they live.

The agency operates community-based clinics on the Upper West Side of Manhattan, the Bronx, Harlem, and Bedford Stuyvesant in Brooklyn. The clinics are JCAHO[15] certified, and serve children in foster care, birth and foster parents, as well as other individuals covered by Medicaid. Full adult medical

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[15] The Joint Commission on Accreditation of Healthcare Organizations

services are available. Most of the doctors at the clinics are multilingual, and representative of the cultures of families served in the community. They are available 24 hours a day through an answering service whose staff is multilingual. A visiting nurse service is also available to families.

St. Christopher's encourages biological parents to go to the clinics for their own primary care, and through partnerships with other health care entities, guarantees them access to specialty medical and mental health treatment and substance abuse services. St. Christopher's also encourages biological parents to remain involved in their child(ren)'s medical care while they are in placement. Biological parents and foster parents attend medical appointments with the child. During this time, they receive information about any medical conditions the child may have, and general information about what is necessary to maintain good health. Once a child is reunited with his or her biological family, the family can continue to receive care at the clinic.◆

■ Community-based provider networks and agencies

HealthWorks of Illinois
Cook County, Illinois and State of Illinois
HealthWorks, a health care system implemented by the Illinois Department of Children and Family Services (DCFS), was designed to serve all 31,000 children in foster care in Illinois, with the exception of those living in a detention facility or an inpatient psychiatric hospital. The model for HealthWorks is based on a primary care, preferred provider approach. Although it incorporates some "managed-care-like" attributes, HealthWorks uses a fee-for-service payment arrangement for providers and is not a managed care system. By contracting with an organized consortium of community-based agencies in Cook County (where 70-75% of children in custody live) and with the Department of Human Services for the remainder of the state, DCFS established community-based lead agencies throughout the

state to administer HealthWorks. Lead agencies are responsible for developing extensive networks of qualified providers so that each child will have access to a primary care physician to coordinate his or her overall health care services. Lead agencies determine which providers to enroll and use multiple strategies to entice them to participate in the HealthWorks network. In Cook County, providers were solicited based on their location (in zip code areas where most children in foster care live) and their qualifications. In addition, lead agencies directly approached individual providers who were already serving children in foster care and invited them to join the network. HealthWorks has pursued many creative strategies to expand the number of providers willing to participate in the network. Incentives include a $15 fee to initiate a child's Health Passport, speeding up the Medicaid payment process, and an average 13% higher Medicaid rate structure for physicians enrolled in Illinois' Healthy Moms/Healthy Kids program. In Cook County, HealthWorks participating providers serving children in DCFS custody receive a $5/month/child patient management fee. Each primary care physician is a pediatrician, family practitioner, or an OB/GYN. They must have admitting privileges to a hospital, be board-certified or board-eligible, provide 24-hour coverage, agree to complete the HealthWorks forms and Passport, and cooperate with a medical case manager. Primary care physicians provide well-child exams according to the EPSDT schedule or annually (whichever is more frequent), and make referrals for specialty care.◆

■ Providing access to specialty medical care

For children in the foster care system, access to specialty care can stem from a good system of primary care. In this study, we found that an agency or community's approach to the delivery of primary care often influences the way specialty care is accessed. For example:

- Foster care clinics (and their medical directors) typically maintain strong

relationships with hospitals or medical centers in the community. These relationships offer a ready access path for children needing specialty care.

- Communities that have created provider networks, such as Illinois, offer primary care physicians the ability to refer children directly to specialists without prior authorization.

- Another way of ensuring access to specialty care involves the role of the care coordinator (discussed in Chapter 6) who can help caseworkers and families identify and access appropriate providers in the community.

The Children's Aid Society/Mount Sinai Medical Center Collaboration
New York City

The Children's Aid Society is a private child welfare agency serving approximately 700 children in foster care in New York City. The agency provides primary care services through a foster care clinic co-located at its Midtown Manhattan headquarters, as well as through community-based clinics in Harlem and the South Bronx. In the past, The Children's Aid Society relied mainly on private practice physicians to provide specialty services when they were needed. This was expensive, because rates had to be negotiated with each specialist, and the negotiated rates were typically higher than Medicaid rates. The agency paid for the costs of specialty care out of its Medicaid per diem (a set rate paid to the agency to cover the costs of each child's medical care). The Children's Aid Society was beginning to see children with more severe and complicated medical conditions, and recognized the need to partner with an institution with the medical and technical expertise to address children's

needs. This was particularly important because of the needs of over 100 children served through the agency's Medical Foster Boarding Home program, which serves children with severe or chronic medical conditions.

In response, The Children's Aid Society began a process of formalizing an existing relationship with Mount Sinai Medical Center, which had been seeing many of the children, in order to capitalize on the existing strengths of the two institutions. Mount Sinai pediatricians now staff The Children's Aid Society clinics, and a full-time practice manager from Mount Sinai was placed at the agency's headquarters. Through this arrangement and the establishment of a cooperative referral process, children in the care of The Children's Aid Society are able to more easily access specialty and inpatient services at Mount Sinai. The process of obtaining specialty care has been streamlined by having a referral coordinator at each institution who facilitates access to all of the medical and surgical specialties. Several appointments can be coordinated at once with the hospital, and all appointments are tracked and logged. Any problems, such as appointment changes or urgent needs, can be quickly addressed through the referral coordinators. While The Children's Aid Society still utilizes other referral sources (such as its own mental health services), children have access to 29 specialty pediatric clinics through Mount Sinai.[16] Mount Sinai bills Medicaid directly for specialty services that are provided. The two organizations also have established guidelines, standards of care, and policies and procedures for integration of services and coordination of care. ◆

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[16] This approach has the added benefit of providing a learning experience about the health care needs of children in foster care for residents rotating through the pediatric clinics; however, a potential drawback is the lack of continuity of care due to routine turnover among medical residents. Thus, staff at The Children's Aid Society felt that it was important to establish relationships with hospital attending physicians.

TOPICS FOR DISCUSSION

Is a Foster Care Clinic Right for Your Community?

Stakeholders concerned with the health of children in foster care hold strong opinions regarding whether children are best served through a centralized clinic specializing in foster care, or by providing families with access to community or neighborhood-based services and a choice of providers. The decision is not an easy one, as each option has advantages and disadvantages. The following questions are provided to assist in making this decision.

1. Which approach fits the location and geography of the community?

☐ How large is the city/county and the number of children to be served? (Will some families have to travel long distances to reach the clinic?)

☐ If the geographic area is large, will there be only one clinic, or a main clinic with satellite locations?

☐ Will the clinic be accessible by public transportation? Will ample parking be available?

2. What are the benefits of co-location with child welfare offices?

Respondents described a number of benefits that are derived from locating a foster care clinic in the same building as the child welfare agency's offices. These include:

– the opportunity for enhanced communication between clinic staff and social workers; medical staff are available on-site to explain health care issues and provide informal consultation to social workers;

– a sense of shared mission;

– foster parents tend to stop by at the same time that they come to see social workers, thus health care providers have the opportunity to see a child more frequently;

– having all paperwork in the same building results in less time spent having to track down copies of records.

3. What are the drawbacks of co-location with child welfare offices?

Respondents cited the following drawbacks of co-location that should be considered:

– time constraints resulting from more frequent "walk-in" visits;

– potential confusion for children who identify the clinic as being in the same building where visitation with their biological parent(s) takes place;

– for older children and adolescents, there may be a stigma associated with receiving care at a location clearly identified with foster care placement.

4. Will other services be provided at the clinic in addition to primary health care?

☐ Dental care?

☐ Developmental screenings?

☐ Mental health services?

☐ Family support services?

TOPICS FOR DISCUSSION *continued*

5. How will the clinic be staffed?

☐ Will the clinic be staffed by providers who represent the cultures of children being served?

☐ Are funds available to cover the costs of clerical staff as well as nurses or other individuals who can provide care coordination?

☐ Will there be a designated liaison between the clinic and the child welfare agency/caseworkers?

6. How can the clinic be made family friendly?

☐ Will the clinic offer evening and weekend hours?

☐ Will families have access to a 24-hour on-call line?

☐ Will waiting areas be comfortable and welcoming for families and children, with toys and play space?

☐ Will biological parents be able to attend health care visits with their children?

Developmental and Mental Health Screening, Assessment, Services and Treatment

Discussed in this Chapter

Strategies that states and communities are implementing to:

- Conduct developmental and mental health screenings and assessments when children enter care

- Ensure access to developmental and mental health services and treatment

In this chapter, we present a group of approaches that focus on addressing the developmental and mental health needs of children in the foster care system. Respondents in the study indicated that accessing services in these areas is more challenging than accessing other types of specialty care. Some mentioned that it is difficult to obtain services for children with mild or moderate mental health needs, whereas systems already exist in their community for serving children with severe mental health needs. The transient nature of foster care placements also poses difficulties in terms of identifying developmental delays in young children, linking them to early intervention services, and maintaining continuity of services when children move or return home.

In the descriptions of programs (approaches) provided here, several aspects of each are highlighted. These include:

- how children are referred to the program;

- how the program provides access to a continuum of services, including screening and assessment, treatment provision or linkage to appropriate services, and periodic reassessments;

- how birth and foster families are engaged in the assessment and service delivery approach;

- how the program's services are utilized to facilitate permanency planning; and

- how the program is funded.

Strategies and Approaches

Within this framework, we present:

- Several approaches specifically designed to address the developmental needs of young children;

- Approaches that provide comprehensive assessments and access to mental health services for every child entering care;

- A therapeutic foster care program that provides culturally relevant services to American Indian youth;

- An approach that enhances access to mental health services in a managed care environment.

■ Addressing young children's developmental needs

Services to Enhance Early Development (SEED)
Alameda County, California

The SEED program provides comprehensive mental health and developmental assessments, case management and family-focused services to a group of 100 children under age 3 entering the foster care system in Alameda County, California. The program is a collaboration between the Alameda County Department of Children and Family Services (DCFS) and the Center for the Vulnerable Child (CVC)—a hospital-based pediatric center at the Children's Hospital in Oakland, California. The primary goal of SEED is to complete early mental health and developmental assessments of young children as they enter foster care and to stabilize them in a permanent placement as soon as possible.

When a child is assigned to SEED, a public health nurse—housed at the county child welfare agency—immediately visits the birth parents to gather health information about the child, and with the social worker, visits the child in the foster home. The nurse also collects information from previous health care providers. Once the child is stabilized in the foster home, a psychologist from SEED visits to conduct an in-home assessment of the child. The instrument used for this assessment is the Functional Emotional Assessment Scale for Infancy and Early Childhood (Greenspan, 1992). The in-home assessment and the additional information gathered from the birth and foster parents create a vivid picture of each child's unique strengths and needs. The assessment information is presented at weekly clinical team meetings, which are attended by child welfare and CVC staff. An individual

service plan for each child is developed at this meeting. The results of the weekly clinical team meetings are described to the birth and foster parents.

The responsibility for case management depends on each child's needs and may be provided by either the child welfare worker or CVC staff. Each child welfare worker involved in SEED works with no more than 25 children, and if possible, serves the same children throughout their time in the program, even after reunification or adoption. The clinical team supports concurrent planning, a process in which the child welfare agency simultaneously provides time-limited reunification services for the child's family and explores other permanent options in case reunification is not attained. It is the SEED philosophy to find a stable placement for each young child as quickly as possible.

Some of the support services offered by SEED include family visitation at CVC, parent support groups, home visits, intensive mental health consultation and treatment, and respite nursery services at CVC. Additional services offered by CVC and by the Children's Hospital Oakland are available to children enrolled in SEED. The SEED public health nurse and case manager assure that each child's health care needs are met either by CVC or through referral to other providers. If a child remains in placement after 1 year, s/he receives a full mental health and developmental reassessment. Children who are returned home or adopted, and their families, can continue to receive medical care at CVC, if they choose to do so.

SEED was initially implemented as a pilot project, with funding provided by a private foundation. This funding enabled CVC to hire staff and provided partial support for the public health nurse employed by DCFS. Services of two psychologists are paid by Medi-Cal (billed on a fee-for-service arrangement). DCFS leveraged federal funding to match the foundation support for the public health nurse position. DCFS provided the social work and supervisory positions. The

Addressing Children's Developmental Needs: Focus on Training

It is critical that child welfare professionals and early intervention professionals know and understand each others' fields in order to ensure timely access to and continuity of developmental intervention services for young children in foster care.[17] Caregivers must also be included in relevant training programs.

The Starting Young Program offers workshops for caregivers on developmental, social, and emotional needs of babies; health care and hygiene; and behavior management. Workshops are available to Department of Human Services and private agency workers on a bimonthly basis on "Identifying Infants and Toddlers at Risk" and "Meeting the Needs of Medically Complex Children."

The newest component of the **SEED Program** is a training/consultation model that will disseminate information about the child-focused, enhanced clinical decision-making model offered by SEED to all child welfare workers in Alameda County, California who work with children under age five.

A set of three handbooks and accompanying videotapes—**Serving Children with Disabilities Handbooks for Child Welfare Workers**—has been developed by the Georgetown University Child Development Center, with funding from the U.S. Department of Education's Office of Special Education Programs (OSEP). The handbooks and videotapes provide child welfare personnel and other professionals with information about various developmental disabilities to help them recognize signs of disabilities in the children they serve. See http://gucdc.georgetown.edu/handbooks.html for more information and to download copies of the handbooks.

program has now completed its 3-year pilot phase, and is currently being sustained and expanded through other funding sources. Through a contract under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) of Medi-Cal, SEED can serve 100 additional children. The contract pays for the CVC staff and for the assessments

conducted by the psychologists. Additionally, SEED II, an expansion of the original program, is serving 60 children aged birth to five. With the EPSDT contract and continued commitment of Alameda County, grant funds are no longer needed or used. ◆

The Starting Young Program
Philadelphia, Pennsylvania

The Starting Young Program is an interdisciplinary, pediatric developmental follow-up program for children up to 30 months of age. Based at the Children's Hospital of Philadelphia, Starting Young aims to improve health and developmental outcomes for infants and toddlers served by the Philadelphia Department of Human Services (DHS), whether they are in foster care or receiving in-home services. The program was developed in response to the large number of children entering foster care who had medical and developmental problems, yet underutilized health care and early intervention (EI) services. Children were being identified too late to take advantage of early intervention services, and many workers in the child welfare system were unaware of children's entitlement to EI services under under Part C of the Individuals with Disabilities Education Act (IDEA).

Children are referred to the program by DHS social workers, or by any of the 40 agencies under contract with DHS. When a referral is received, the Starting Young team social worker contacts both the child's social worker and current caregiver (birth or foster parent) by phone to conduct an intake interview and set up an appointment for a comprehensive assessment. Children are evaluated by members of the clinical program's interdisciplinary team composed of a developmental pediatrician, an audiologist, a child psychologist, a speech-language pathologist, a physical therapist, and a pediatric social worker. A pediatrician also conducts a physical health care evaluation. The

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[17] Spiker, Donna, and Judith A. Silver. "Early Intervention Services for Infants and Preschoolers in Foster Care." In *Young Children and Foster Care*, edited by Judith A. Silver, Barbara J. Amster, and Trude Haecker. Baltimore: Paul H. Brookes Publishing Company, Inc., 1999.

caregiver and child welfare worker who accompany the child are given feedback about the evaluations at the conclusion of this session.

Once a report is created based on the comprehensive assessment, the child's social worker assures that the recommendations are implemented. Children who are eligible for early intervention services are linked with the local EI service coordinator who explains the available services and the child's federal entitlement under Part C. In some cases, the Starting Young pediatrician will contact primary care providers of children with special problems to facilitate treatment.

Children are reevaluated every six months until they reach 30 months of age, regardless of changes in their placement status. As a means of follow-up, the Starting Young Program team social worker contacts the child welfare worker within 8-12 weeks of the evaluation to determine whether there have been any problems in accessing the recommended services. If the recommendations have not been implemented, the Starting Young Program team social worker works with the child welfare worker to resolve any problems.

The Starting Young Program was initiated with grant funds from a private foundation. Current funding sources include Medicaid, Early Intervention, and the Department of Pediatrics at Children's Hospital of Philadelphia.◆

The Developmental Screening and Enhancement Program (DSEP)
San Diego County, California

The Developmental Screening and Enhancement Program (DSEP) was initiated as a demonstration project in San Diego County to address the developmental needs of children in the child welfare system through identification and linkage to early intervention services. The project serves children under the age of six who enter the Polinsky Children's Center—a receiving center serving children in the county who are removed from their homes. DSEP was developed in response to the growing needs of children in the county's foster care program,

two-thirds of whom tested below normal developmental levels.

Children between 3 months and 5 years 11 months of age are screened for developmental delays while they are staying at the Polinsky Children's Center. The screenings are administered by pediatricians and nurse practitioners during the children's initial physical exam upon entry into the center. If further evaluation is needed, an on-site psychologist conducts a more extensive evaluation using a battery of speech, language, and psychological tests.

Children identified as developmentally delayed are referred to developmental intervention services. Six months of in-home support services are also provided to caregivers through a paraprofessional home visitation agency or a county public health nurse. The in-home visitation services provide caregivers with strategies for enhancing the child's development and assist them in accessing early intervention services. DSEP staff collaborate with social workers to track individual children in foster care to ensure that early intervention services continue if the children change placements, and they assist social workers with obtaining needed services for the children while they are in care. The project provides social workers with a report detailing the services available in San Diego County for children with developmental delays. Findings from a research component of this program highlighted the need for policies that would expand these support services to kinship providers and biological families.

An augmented version of the Developmental Screening and Enhancement Program now makes developmental screenings available for children who bypass Polinsky Children's Center and are placed directly in the homes of relatives or foster care providers. Speech evaluation and on-site intervention services at the Polinsky center have been added, as well as technical support and education to staff working at the center. This augmented version of DSEP is currently grant funded. As a result,

the DSEP leadership team is exploring sources of sustainable funding for these supplementary program components.

Funding for DSEP is provided by the Division of Developmental Services at Children's Hospital San Diego, the Child Abuse Prevention Foundation, the San Diego County Health and Human Services Agency, the Child and Adolescent Services Research Center, the Center for Healthier Communities for Children at Children's Hospital San Diego and the San Diego County Children and Families Commission (Proposition 10). Medi-Cal (California's Medicaid program) covers a portion of the cost of developmental assessments and case management services. ◆

■ Comprehensive assessments and access to mental health services

The Family Program (Westchester Institute for Human Development)
Westchester County, NY

The Family Program is a collaborative effort between the Westchester Institute for Human Development (WIHD) and the Westchester County Department of Social Services (DSS) designed to meet child welfare permanency goals by providing developmental and mental health assessments and services to all children in family foster care in the county, their birth parents and their foster families.

Referrals from DSS to the Family Program are made in two ways—through a DSS tracking form that notifies the program of all new entries into foster care, and by referral from the Pediatric Unit, a DSS clinic that provides primary health care services for children in custody in the county.

The assessment process at WIHD has two components:

• **Initial Intake Assessment**
  The Initial Intake Assessment consists a comprehensive developmental assessment for

> **Some Findings from Research**
>
> Researchers examining service delivery for children seen in a specialized foster care clinic and children who received routine services from providers in the community found that community health care providers were more likely to identify and refer children entering foster care for evaluation and treatment of physical and educational concerns than for developmental and mental health problems.[18]
>
> Researchers with the **Developmental Screening and Evaluation Project** in San Diego found that young children placed in kinship care are as likely to be developmentally delayed as those placed in non-relative foster care, yet children in kinship care tend to receive fewer services. The findings suggest that children must have access to developmental intervention services regardless of placement type.[19]

the child, and a functional assessment of birth parents. All children and their biological parents are referred to the Family Program when a child comes into care. The DSS caseworker notifies the parents, and brings them to WIHD for the assessment. An initial, 3-hour assessment of the child and family consists of a social work intake, parent screening (cognitive functioning and three other questionnaires), evaluation of the child by a psychologist, and an assessment of parent-child interaction. Based on the results of the intake assessment, other evaluations as necessary are completed by members of the child development team including developmental pediatrics, child psychiatry, a psychoeducational specialist, speech/language pathology, occupational and physical therapy, and audiology. Specialized referrals may also be made to child neurology and other pediatric subspecialties available onsite.

• **In-Home Assessment (foster home)**
  A visit to the foster home by a psychologist is conducted when a child comes into care to assess the "fit" between the foster home environment and the child and to identify

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[18] Horwitz, Sarah McCue, Pamela Owens, and Mark D. Simms. "Specialized Assessments for Children in Foster Care." *Pediatrics* 106 (2000): 59-66.

[19] Leslie, Laurel K., Jeanne N. Gordon, William Ganger, and Kristin Gist. "Developmental Delay in Young Children in Child Welfare by Initial Placement Type." *Infant Mental Health Journal* 23 (2002): 496-516.

immediate and ongoing supports that the foster family may need in order to maintain the child's placement.

Ninety percent of children seen at WIHD for Initial Intake Assessments receive services through the Family Program. These services include:

• **Clinical Services (developmental and mental health interventions)**
If intervention services are indicated, the child can receive mental health services under the supervision of a child psychiatrist including play therapy, individual therapy, group therapy, and/or developmental interventions such as speech/language services and educational tutoring at the Family Program and WIHD. Children who require medication for their symptoms can be treated by the Family Program's psychiatrist. Mental health services are provided with the goal of stabilizing children, helping them deal with symptoms such as depression, anger, attention difficulties and other reactions to their trauma. WIHD is an approved provider of Early Intervention Services and Early Childhood Services. The Family Program also relies on several auxiliary programs of the WIHD or Medical Center to provide services to children and their families. For example, the Learning Evaluation and Achievement Program (LEAP) provides psycho-educational assessment and intervention services, direct specialized instruction, consultation and related services to children referred by the Family Program, schools, or parents. Other services available are speech-language, otolaryngology, assistive technology, and pediatric neurology.

• **Training and support for birth families and foster families**
Family Connections at WIHD, which is staffed by parents of children with disabilities, assists new families who are participating in early intervention services by contacting the family, sending out a welcome packet, talking to the family about the evaluation and helping the family understand the IFSP process.

Enhanced Foster Care services are designed to support foster families who need assistance in managing a child who has significant behavior and/or developmental problems. A year-long, in-home support/training program is provided, as well as recreational activities for children outside the home which provide respite for the foster families.

Through the *Parent-Child Program,* parent training services and family therapy are offered to birth parents together with their children to improve parents' ability to safely care for their children and facilitate the timely return of children to their care. Since the intervention needs of this population are so complex, a Parent Training Curriculum has been developed that addresses basic parent skills training and provides a format for dealing with difficult, sometimes traumatic material. These interventions allow for ongoing assessment of readiness for family reunification and require a substantial commitment to providing technical assistance to the DSS worker, Family Court, and other professionals providing medical, developmental, and mental health services to the family. The curriculum is implemented with the parents during a one-hour per week session. Routine activities for staff include attending six monthly Service Plan Reviews and testifying in Family Court to assist in case planning.

Family Program services are funded through contracts with DSS and through Medicaid billing. DSS contracts with WIHD to conduct the In-Home Assessments, Initial Intake Assessments, and the Enhanced Foster Care program. DSS, in turn, bills Medicaid for these costs. WIHD bills Medicaid directly for its clinical services (developmental and mental health intervention services). ◆

Foster Care Mental Health Demonstration Project
Monroe County, New York

Several years ago, the Medical Director of Monroe County Foster Care Pediatrics (the clinic providing comprehensive, primary care

services to children in foster care) received a CATCH grant from the American Academy of Pediatrics to examine gaps and overlaps in the system with respect to mental health services for children in foster care. From that grant, a booklet was developed that highlighted gaps in the system, and some funds from the county Office of Mental Health were obtained to organize a task force. System-level issues that the task force wanted to address included the issue of consent for mental health evaluations and treatment, the need for early assessments when children come into care, and the need for a preventive (rather than crisis-oriented) mental health approach.

The task force released an RFP as part of a demonstration project to provide mental health evaluations for every child entering foster care. All six mental health provider agencies in the county responded to the RFP. Strong Memorial Hospital was one of two agencies selected to participate in the project, and ultimately the hospital assumed responsibility for conducting all of the evaluations. Now, all children receive a comprehensive mental health assessment, typically within 60 days of entry into foster care, or sooner if a caseworker has concerns. When a child first enters care in the county, his or her biological parent/guardian signs a consent to medical care, including mental health care, for the child.[20] (See the example on "Developing a Consent Protocol" in Chapter 3.) This consent protocol eliminated one obstacle to conducting timely mental health assessments.

In order to initiate the assessment process, a release form signed by a Department of Social Services (DSS) official is faxed to project staff at Strong Memorial Hospital, along with other forms containing relevant background information. Clinical staff then contact the foster parent to set up an appointment for the assessment. The assessment process generally consists of two evaluation sessions and one feedback session. The assessment protocol is

individualized based on the age of the child, and utilizes a combination of standardized instruments, clinical interviews, and observation. Younger children have one evaluation session, which focuses on developmental and attachment issues. Foster parents accompany children to the evaluation sessions. Child care is provided for other children in the family so that foster parents can participate. Strong Memorial Hospital has a culturally diverse staff, and interpreter services are provided when needed.

Following the assessment, two reports are generated. A full report is sent to the DSS worker and Foster Care Pediatrics. This information helps the clinical staff at Foster Care Pediatrics to integrate findings of the mental health assessment with physical health care for the child. A report describing strengths, areas of concern, and specific recommendations is provided to the child's foster parents, and is also available for birth parents. Ongoing mental health treatment services are provided for children who require this based on the results of the assessment. Children who don't enter treatment after the assessment receive a follow-up assessment six months later.

This project, begun as a demonstration project, has now been institutionalized. Costs for the mental health assessments are billed to Medicaid. However, the true cost that Strong Memorial Hospital incurs exceeds the reimbursement rate, and is absorbed by the hospital. ◆

■ A culturally relevant approach for Indian youth

In-Care Network
Billings, Montana

The In-Care Network, Inc. is a Montana-based, non-profit (501C-3) corporation that provides therapeutic foster care services for American Indian youth. It is a licensed child placement agency founded to meet the needs

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[20] Separate consent is required for the prescription of psychotropic medications.

of Indian youth with serious health or mental health conditions. 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.

Youth are referred to In-Care by a social service agency. It may be the Bureau of Indian Affairs (BIA), the state, a tribe, or the interaction of all three agencies that determines where the child will be referred and placed. The majority of the youth referred are from tribes in Montana.

In-Care is a child placing agency, not a licensed health or mental health center, therefore In-Care refers children to other providers for assessments. Youth receive an initial mental health assessment with a contracted clinical psychologist within 60 hours of placement.[21] An initial treatment plan is developed within five days and a full treatment plan within the first 30 days of placement with In-Care. The individualized, strength-based treatment plan includes a comprehensive assessment of the child's other needs. Staff and service providers ascertain the child's tribal membership and degree of traditionalism so that the treatment plans can include appropriate cultural interventions. A licensed clinical supervisor monitors the implementation of the treatment plans.

When In-Care accepts a child, a treatment manager is chosen to coordinate the child's care. A treatment team is developed based on the individual needs of the child. When appropriate, the biological parents are included on the child's treatment team. Mental health services are usually set up with Indian Health Services (IHS) or an In-Care contract provider. The coordination of a youth's care is based on the Medicine Wheel as the framework for treatment, emphasizing the concept of restoring balance versus treating a dysfunction. The Medicine Wheel is used as a

visual representation of all the interconnected areas of the child's life—social, physical, mental and emotional—as they affect the child's spiritual development. Highly trained foster parents help In-Care staff address the mental health needs of youth living with them in a holistic fashion.

Culture is the driving force behind In-Care. Helping Indian youth become aware of and maintain their heritage is part of the healing process. Staff understand that the acculturation process is different for each child, and therefore In-Care meets each child at his or her own level of cultural identity. In-Care believes that if a child is in conflict with his or her own identity, it will have negative effects on mental health and must be addressed in their work with the child. In-Care program activities that promote the child's identity and feelings of acceptance include learning about his or her genealogy, Vision-Seekers (for youth 13 to 18 years of age), Grandchild Journey (for children ages 3 to 12), Camp Little Feather (for children ages 4 to 11), Sweat Lodge, and Naming Ceremony.

A mix of funding sources supports the In-Care Network including: Medicaid, state funds, federal Title IV-E funds, Bureau of Indian Affairs, Tribal funds and foundation grants. Stipends to foster care parents account for 30-40% of the budget.◆

■ Enhancing access to mental health services in a managed care environment

The 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 county mental health departments, the Department of Mental Health (DMH) in Riverside became the formal access point for community-based mental health treatment services for all individuals on

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[21] Some clinicians rely on the interview method with Indian youth, because of the lack of standardized assessment instruments normed for this population.

Medi-Cal in the 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 DMH and the Department of Public Social Services (DPSS), the county's child welfare agency. The ACT program was designed to address difficulties DPSS was having in accessing mental health services for children, and to ensure appropriateness and quality of services.

DPSS refers children who need a mental health assessment or community-based counseling services to licensed ACT clinicians, who are employed by DMH and co-located at child welfare offices throughout the county. Additionally, all children ages 3-18 who are placed in shelter care homes (initial placements after they are removed from their own homes), receive clinical assessments within 30 days.

The ACT clinicians provide:

- 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.

ACT clinicians make referrals to a network of community-based providers who can bill Medi-Cal for services. As a result of the Department of Mental Health's efforts to recruit and authorize providers for the Medi-Cal managed care network, the number of providers available to children involved with DPSS has expanded from approximately 50 to 350 providers. This allows the ACT clinician to make a referral to a provider who specializes around the individual needs of a specific child or family. The referral form for ACT services includes space to address cultural issues and specific service needs. ACT clinicians attempt to find and approve community providers who are able to address the cultural needs of families and children served by DPSS.

Individual providers receive authorization for three months at a time. The standard package of services includes weekly individual therapy, and family therapy, if warranted. At the end of the three months, providers send a report to the ACT clinician who will determine with the DPSS social worker whether the child/family needs further services. Requests for extension of services are typically processed within three days. Children with the most serious service needs are usually referred to a county mental health clinic for a comprehensive assessment and access to a wider variety of community-based services than individual private providers offer. A separate, county-level screening committee is responsible for authorizing residential, group home or intensive family services.

DPSS recognizes the importance of including biological family members in services. Foster parents can also participate in treatment services. While ACT clinicians are primarily responsible for accessing services for children involved with DPSS, if parents or other family members need mental health services the ACT clinician can initiate a referral. When a family member who is not Medi-Cal eligible needs treatment, DPSS funds can be used to pay for services. ACT clinicians are able to authorize services for children in their own homes, in relative placements, in voluntary placements, and in foster care.

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

TOPICS FOR DISCUSSION

Addressing Children's Mental Health Needs: Key Questions

The following questions are provided for states and communities to consider when planning or improving comprehensive mental health services for children in foster care.

☐ What kind of screening mechanism will there be to identify children entering care who are in urgent need of mental health services?

☐ What kind of immediate interventions will be available to help children address separation and bereavement issues and to cope with the trauma of placement?

☐ Will mental health consultation be available to caseworkers so that they may better understand a child's mental health needs?

☐ How will background information about the child be provided to the clinician(s) conducting a mental health assessment?

☐ Will a child's strengths, as well as needs, be identified as part of the assessment process?

☐ Will the assessment process for youth address substance use issues and examine the need for substance use services?

☐ Will a child's mental health status be reassessed at regular intervals throughout the stay in care, and upon movement from one placement to another?

☐ Will the strengths and needs of members of a child's birth family be examined?

☐ Will mental health services be offered to other members of a child's family?

☐ Will family members and caregivers be able to participate in the child's treatment?

☐ Will efforts be made to provide culturally relevant mental health services for the child and/or identify a provider who represents the child's culture?

☐ How will mental health, physical health, and educational services be integrated? Will providers in each of these areas have information about the child's other needs?

☐ What kind of aftercare services will be provided when a child returns home, is adopted, or moves to another permanent placement?

☐ Will youth leaving the foster care system to live independently receive assistance in transitioning to the adult mental health system?

Addressing Children's Developmental Needs: Key Questions

The following questions are provided for states and communities to consider when planning or improving comprehensive developmental services for children in foster care.

☐ How will children in need of a developmental screening be identified?

☐ Will all children of a certain age who are removed from their homes receive a developmental screening? (What about children who return home immediately, or are placed with relatives?)

☐ What resources exist in the community for obtaining developmental screenings and assessments?

☐ How will the child welfare system interface with early intervention programs in the community? (e.g., formal mechanisms for linking children to services)

☐ What mechanisms will be put into place to ensure that birth parents have the opportunity to provide consent for and be involved in early intervention services?

☐ What mechanisms will be put into place to ensure the continuity of early intervention services if a child changes placements or returns home?

☐ What training mechanisms will be instituted to enhance the capacity of child welfare workers and families to understand normal child development and to better address the needs of children affected by developmental disabilities?

Management of Health Care Data and Information

Discussed in this Chapter

Strategies that states and communities are implementing to:

- Gather information about a child's health history and health care needs at the time of initial placement

- Record and manage health care data while a child is in placement

- Utilize health care data to aid in meeting child welfare system goals

- Address confidentiality issues around the electronic sharing of data

In this study, we defined the critical component *Management of Health Care Data and Information* as follows:

> *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 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.*

To ensure a child's safety and well-being while in placement, parents, caregivers, agencies, schools and medical providers must have a clear understanding of the child's health care needs, as well as the services and supports required to meet those needs. Accurate information recorded in a child's record and available to those involved in a child's care supports their ability to advocate on behalf of the child. However, all too often, multiple placements and changes in physicians and social workers lead to inconsistent documentation of services. Availability of accurate information is also critical in terms of supporting permanency goals for children as they transition out of the child welfare system to reunification, adoption, or another type of permanent placement.

Strategies and Approaches

■ Gathering Information about a Child's Health History and Health Care Needs at the Time of Initial Placement

This section deals with the collection of health history information and information about a child's health care needs at the time of a child's initial placement in the child welfare system. One of the most frequently cited barriers to the provision of adequate health care services for children in foster care is the lack of any information about their health history when they come into care, as well as the difficulty in obtaining that information. We present here some examples of strategies that are being used to gather existing records. They include strategies for obtaining information from birth parents, as well as from other sources.

■ Gathering information from birth parents

When a child is removed from the home— When a child welfare worker removes a child from the home, safety issues are paramount. Nevertheless, information about a child's health is needed to ensure the child's safety while in foster care. Children are at risk if they have medical conditions unknown to their caretakers (e.g., diabetes, asthma), or if their caretakers do not have the necessary

> **Key Questions Related to Gathering Health History Information**
> - What sources are used to gather health history information when a child comes into care?
> - How is health-related information obtained from birth parents?
> - Who is responsible for gathering and compiling the information?
> - Is health history information made available for review by medical staff conducting comprehensive assessments?
> - Where is health history information recorded?

information to respond appropriately. The New York State (District II) chapter of the American Academy of Pediatrics[22] recommends that the following information and items be obtained when a child is removed from the home:

- contact information for the child's most recent health care providers;
- name of hospital where the child was born;
- any chronic medical problems;
- prior hospitalizations and surgery;
- allergies;
- medications;
- immunization record;
- eyeglasses and medical equipment.

In order to assist social workers during what is typically a traumatic time, the **Los Angeles Foster Care Public Health Nurse Unit** created *Don't Leave Home Without It,* a simple list to remind workers to gather important baseline information about a child's health status when they are removing a child from their home.[23]

At initial court hearings—In circumstances where health information cannot be obtained when a child is first taken into custody, there is also the opportunity to obtain information from birth parents at the time of the initial court hearing. For example, in **Sacramento County, California,** public health nurses go to the court and interview birth parents on the day parents are attending the custody hearing. This strategy was adopted because parents may perceive the nurse to be non-threatening, and thus be more willing to provide information to the nurse than to a social worker. As mentioned in Chapter 3, the **First Judicial District of Pennsylvania** has developed *Healthy Children: A Guide for Parents and Guardians,* a brochure that explains what parents and guardians can do to help ensure that their children receive appropriate health

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[22] Task Force on Health Care for Children in Foster Care. *Fostering Health: Health Care for Children in Foster Care.* Lake Success, NY: American Academy of Pediatrics, District II, NYS, 2001.

[23] A version of this tool can be downloaded from the Parent Educational Advocacy Training Center (PEATC) website: http://www.peatc.org/FosterCare/don't_leave_home.htm

The **New York State Permanent Judicial Commission on Justice for Children**[24] notes that every court proceeding presents an opportunity to inquire about a child's health needs. The Commission developed a checklist of 10 key questions for anyone involved in court proceedings to utilize in advocating for appropriate health services for the child in foster care:

1. Has the child received a comprehensive health assessment since entering foster care?

2. Are the child's immunizations complete and up-to-date for his or her age?

3. Has the child received hearing and vision screening?

4. Has the child received screening for lead exposure?

5. Has the child received regular dental services?

6. Has the child received screening for communicable diseases?

7. Has the child received a developmental screening by a provider with experience in child development?

8. Has the child received a mental health screening?

9. Is the child enrolled in an early childhood program?

10. Has the adolescent child received information about healthy development?

care services while in court-ordered placement. The brochure has a section that explains the health-related information that caseworkers need, and what will be done with the information.

■ Other strategies for obtaining health history information

In many communities, public health nurses are used to track down information that is still missing after a child has entered foster care. For example, the nurses may attempt to get records from a child's school or previous medical providers. Obtaining a child's immunization record is particularly important. Respondents in the study mentioned that lack of this

information results in children being immunized over and over again. One important source of information that is available in some states and communities is an immunization registry. **Immunization registries** are confidential, population-based, computerized information systems that attempt to collect vaccination data about all children within a geographic area.[25] Some immunization registries only contain information on specific sub-populations of children (e.g., children on Medicaid), but increasingly there is a move to have information on all children contained in these registries.

Some states are also engaged in efforts to create **system interconnectivity between child welfare and Medicaid databases** for purposes of compiling a health history for children entering foster care who may have previously been on Medicaid. For example, information contained in Medicaid databases is being utilized to initiate health passports (discussed later in this chapter). This capacity can reduce the amount of time spent tracking down medical records. Information available may include data on Medicaid eligibility, previous providers, and service utilization.

Utah Statewide Immunization Information System
State of Utah

The Utah Statewide Immunization Information System (USIIS) is a statewide, public/private immunization registry encompassing all providers and all children in Utah. The Fostering Healthy Children Program is a participant in this system. Public health nursing staff are trained on the use of WebKids, a USIIS site that allows the nurses, as authorized users, to obtain immunization records for children entering foster care. Users must access the system using a login ID and password, and the site uses encryption to protect transmitted information. ◆

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[24] 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, 1999.

[25] More information on immunization registries can be obtained from the CDC's National Immunization Program website: http://www.cdc.gov/nip/registry or from http://www.allkidscount.org

Health Passport
State of Michigan

In 1998, legislation was passed in the State of Michigan requiring that every child in state protective custody have a medical passport. This legislation also included a court order stating that a child's medical records must be released to the child welfare agency if the child is in state protective custody. The legislation grew out of complaints from adoptive parents that they had no knowledge of prior medical history when a child was adopted. The child welfare agency was also having difficulty accessing children's medical records, even though required to do so.

The medical passport was designed with standardized fields to match fields used in Department of Community Health databases, because the state is planning to develop a system that will enable the electronic transfer of data between the health department and the child welfare agency. The data will include immunization records, as well as Medicaid records for children who were covered by Medicaid prior to entering care. When the electronic system is first implemented, the child welfare agency will provide an electronic list of all children currently in care, and the Department of Community Health will transfer relevant data for those children based on uniform client IDs. Subsequently, health information for children remaining in care and new children entering care will be transferred on a regular basis. ◆

■ Recording and Managing Health Care Data While a Child is in Placement

In this study, we obtained information about several approaches used to document health histories and needs, as well as services received by children while in placement. These included use of **standardized medical forms, health passports** (paper and computerized), **statewide**

management information systems, and **Internet-based systems**. The most common approach utilized by the respondents in this study was the health passport, which is consistent with the findings of a 1997 survey conducted by the National Academy for State Health Policy.[26] In that study, 32 of 40 responding states indicated that they had some sort of passport system, with the majority of systems being statewide. Eight of the states reported that their passport system was computerized.

■ Standardized medical forms

Some communities have developed standardized health record forms for providers to use at a child's health exam. The intent is to ensure that children are receiving care according to certain standards (e.g., EPSDT standards), and to ensure the uniformity of records across all children in custody. Providers are required to send all completed paperwork to the designated person or unit that tracks the health care services children receive.

■ Health passports

A health passport is a personal health record that is used to record health care information while a child is in foster care.[27] The passport may contain sections for recording a child's medical history, demographic information, immunization records, health care visit summaries, medications, test results, growth information, insurance information, and other special health, mental health and developmental information. Some passports also record educational information or information about a child's placement history. The passport is a significant document in that it can serve as a tool to prevent unnecessary and duplicative medical treatments, and avoid the over-prescribing of medications. It also is designed to move with the child from placement to placement. Ideally, the passport is

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[26] Lutz, Lorrie L., and Jane Horvath. *Health Care of Children in Foster Care: Who's Keeping Track?* Portland Maine: National Academy for State Health Policy, 1997.

[27] An example of a health passport is available on the PEATC website: http://www.peatc.org/FosterCare/overcoming_barriers.htm The document is referred to as a Health Profile, rather than a passport, because the developers felt that the term passport could be misleading for immigrant or undocumented families.

provided to birth or adoptive parents so that they have a record of services provided while a child was in care.

Paper passport systems—Most passport systems currently in use are strictly paper systems. Typically, the passport is provided to foster parents in the form of a booklet, which may include forms for physicians to fill out during medical visits. In some cases, data collected upon the child's entry into care and from initial health screenings is entered on the passport before it is given to the foster parent. Respondents in this study reported a number of barriers to the successful implementation and utilization of a paper passport system, including:

- passports are frequently lost, and thus do not move with the child from placement to placement or when the child returns home;

- lack of a centralized system to track whether or not passports are being utilized;

- lack of clarity about who has the ultimate responsibility for upkeep of the passport, as completion is dependent upon too many individuals (foster parents, providers, social workers);

- burden on foster parents to ensure that passports are brought to every medical visit and that providers fill them out.

In addition, some respondents felt that it was important to streamline passports so that they were not so long and complicated that they went unused. However, others felt that existing passports were not extensive enough to record necessary information for children with special health care needs. To address this latter issue, the Children's Special Health Care Services Program of the Indiana Department of Health worked with a group of parent leaders to develop a **Medical Passport for Children with Special Health Care Needs**. A flexible notebook was created with forms to help document the extensive care needs and to log contacts and medical care provided to children in foster care with special health care needs. The forms are also available on a CD ROM so that they can be downloaded and modified.

Computerized passport systems—Some communities have developed computerized passport systems to house passport data in a centralized location, thereby preventing loss of information as a child moves from placement to placement. One prominent model for a computerized passport system was developed in **San Diego County, California,** and has since been adopted statewide in California as well as in other locations including Washington State and Anchorage, Alaska. In this model, public health nurses are used to coordinate the passport system. The nurses seek out health history information, review medical records, and (with the assistance of health clerks) enter information into a computerized database. Printouts of passports from the database can be generated for parents and social workers. Some key benefits of this approach that respondents discussed include:

- the extensive medical knowledge that public health nurses bring to their review of

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Key Questions Related to Designing A Successful Passport System

The following questions were derived in part from a list of passport issues identified by the National Academy for State Health Policy.[28]

- Will the system be paper or electronic?

- Who is the party responsible for initial creation and then ongoing upkeep of any particular record (nurses, caseworkers, foster parents, doctors)?

- What are the procedures for updating the passport? (e.g., central file is kept with foster parent, central file is held at the state or county office with updates mailed to foster parents, providers mail in encounter forms, providers add information directly to the passport)

- If the central file is not kept with the foster parents, how frequently will information be provided to them?

- What are the procedures for ensuring that birth and/or adoptive parents receive copies of the passport?

- What are the contents of the passport?

- What are the sources of information for the passport? How timely is this information?

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[28] Lutz, Lorrie L., and Jane Horvath.

medical data aids in making more appropriate health care decisions;

• the work of public health nurses on passport systems has brought about true collaboration between public health and child welfare, particularly when nurses are co-located at the child welfare agency.

Maintaining the computerized passport requires large amounts of time on the part of public health nurses. Thus, extensive clerical support is essential. Nurses must also provide training and ongoing support to child welfare workers and foster parents to educate them about the passport system. Some reported limitations of computerized passport systems include:

• challenges around getting data entered and a passport provided to foster parents in time to bring to the child's first preventive health care exam;

• ongoing challenges in obtaining past health histories (thus, what is maintained in the database is just a summary of obtainable information, not a comprehensive health history);

• the number children needing new passports and passport updates can exceed the system's capacity if there are too few nurses and clerical staff;

• need for a system to notify nurses when a child changes placement, in order for them to ensure that the new foster parent is given an updated copy of the passport;

• the system is still reliant on foster parents and providers to submit records so that passports can be updated.

■ Statewide management information systems

In a few states, the computerized health passport system is part of the state's larger statewide automated child welfare information system (SACWIS). That is, the passport is a "module" within the larger system utilized by child welfare agency staff. In other states, child welfare or health department management information systems are utilized to store

children's health-related data, though the data are not necessarily a part of a formal passport system. Integrating health data within a statewide system serves several purposes:

• the data can be centrally accessible to all those involved in case planning for the child;

• alerts can be incorporated into the system to notify caseworkers when screenings, immunizations, or other medical appointments need to take place (these alerts are sometimes incorporated into standalone passport databases as well);

• if a child moves to a different area of the state, data are accessible to new workers involved in the child's care.

■ Internet-based systems

Increasingly, the Internet is being looked at as a tool to facilitate the entry and sharing of health-related information between stakeholders involved in a child's care. Typically, an authorized person uses an Internet browser to connect with a database housed on a secure server. Users are required to enter a log-on name and password to access or transmit data. Some states are exploring the idea of Internet-based passport systems, and having providers utilize Internet systems to record results of assessments and exams, thereby eliminating the need to track down paperwork from providers. Because these types of systems are relatively new, issues such as confidentiality protections need to be addressed, as well as the willingness of providers to utilize them.

EXAMPLE: Multi-faceted approach to data management

HealthWorks of Illinois
Cook County, Illinois and State of Illinois

HealthWorks of Illinois employs a multi-faceted approach to recording and managing health care data for children in state protective custody. This includes use of standardized medical forms, a paper passport system, and child welfare and health department computerized management information systems.

Standardized medical forms—A set of standardized forms has been created for the HealthWorks program to ensure that children in foster care receive health care according to EPSDT standards, as well as to provide a uniform central health record for each child. Standardized forms were produced for routine health visits, acute care visits, referrals, comprehensive history, problem list, and immunizations. One copy of each form (except the problem list and immunization form) is sent to the HealthWorks lead agency, which keeps a permanent health record for each child. When a child changes physicians, copies of the child's previous medical records are sent to the new physician.

Health Passport—HealthWorks utilizes a paper passport system to document a child's medical history and to summarize his or her ongoing health care. The passport is portable and is intended to follow a child through various placements, including a return home or other permanent placement. The passport is to accompany the child to each health visit. The child's caseworker and physicians complete sections of the passport. As an incentive, providers receive a $15 fee for initiating a health passport. The foster parent is to ensure that the passport is given to the physician and that it is passed on to the caseworker to give to the next caregiver when the child leaves the foster home. Illinois' passport is available in both English and Spanish versions.

Health Care Information System—The Health Care Information System (HCIS) is a component of the statewide Child and Youth-Centered Information System for the child welfare agency. HCIS was designed to capture health information on children enrolled in HealthWorks. However, at the time of the site visit conducted in Summer 2000, only the lead agency serving Cook County had linkages to HCIS. HCIS records the following information for children in HealthWorks:

- scheduled and actual dates of the initial health screening, comprehensive health

evaluation, annual exams, age-specific well child exams, and acute visits;
- providers of the above services;
- summary of exam findings;
- selection of primary care provider and history;
- selection of specialty care providers and history;
- assignment for interim and ongoing medical case management services.

Cornerstone Information System—Medical case management services for children enrolled in HealthWorks are provided on an ongoing basis for children under age six. Children ages six and over receive medical case management services on an interim basis for the first 45 days after entering care. The state Department of Human Services contracts with local health departments and community-based medical case management agencies to provide these services. Medical case managers for children in foster care record health care information obtained on each child into Cornerstone, the computerized information system used by the local health departments. This includes demographic information, well child visits (EPSDT), immunization history, birth data, health assessment and age-appropriate anticipatory guidance information. Referrals to other providers for services such as specialty medical care and Early Intervention also are entered into Cornerstone. An Individualized Care Plan including goals and planned services is generated when all necessary information has been entered. Case notes are entered whenever pertinent. In addition to medical information, various historical elements related to the child's administrative case review process are also recorded in Cornerstone. This includes dates of protective and temporary custody, initial health screening and comprehensive health exam, primary care physician's initiation of the Health Passport, along with the name and phone number of the child's caseworker. Cornerstone provides prompts about scheduling routine services. One current barrier is that the Cornerstone system is not accessible to child welfare caseworkers. ◆

EXAMPLE: Computerized passport system

Health and Education Passport
San Diego County, CA

The primary strategy for managing health care information used in San Diego County is the Health and Education Passport (HEP). The Health and Education Passport is a computerized system designed to help maintain and distribute an accurate summary of medical information for children in foster care and to improve the quality and appropriateness of care they receive as they move through the system. Public health nurses and extensively trained clerical staff manage the passport system.

Identifying children who need a passport— Passport clerks use multiple sources to identify children who need a passport. These sources include: the daily Legal Unit Detention Calendar, a list of children without a passport generated every 3 months from the child welfare information system, and CHDP exam forms[29] and other provider encounter forms.[30]

*Gathering health care information—*The clerks gather information for the passport from the social worker's case file, a health questionnaire that is sent to foster parents and birth parents (these are not always returned), records that are requested from identified sources, and records of screenings conducted at the county receiving center. (A clerk is assigned to the receiving center to obtain this information.) The clerks can also access the statewide computerized immunization registry to download information.

*Entering health care information—*The public health nurses summarize, synthesize, verify, and enter medical information into the passport system. They are assisted by the passport clerks, who enter some information, such as immunization data and basic medical information from the well-child exam forms. The clerks highlight information they have entered, and the nurses check it for accuracy.

*Sharing health care information—*After the passport is opened and information gathered, it is sent to the public health nurse for review. A printout of the completed passport is sent to the foster parent and social worker. As the social worker obtains more information, he/she is encouraged to send it to the public health nurse. The social workers do not enter data into the passport. Rather, when a passport is updated with new information (e.g., CHDP exams, further assessments, etc.), a new copy is sent to the foster parent and social worker. Foster caregivers are to send the latest update of the passport with the child when he/she moves to another home or placement.

*Ensuring use of the information—*To ensure utilization of the passport, the public health nurse contacts the foster parent after each new passport is issued. This is to answer any questions about the passport and to encourage the foster parent to take it to all provider visits. The nurse also conducts both initial and ongoing training with social workers, foster parents and providers about using the passport.

Fifteen thousand children have been given a passport over the last 10 years, but at the time of the site visit conducted in Summer 2000, there was a backlog because of the high demand for new passports and passport updates. With new state legislation authorizing 13 additional public health nurses, the county hoped this problem would be resolved. ◆

EXAMPLE: Internet-based system

Web-Based Assessment Tool
State of Texas

Through a public-private partnership funded primarily by the Texas Department of Protective and Regulatory Services and supported by the efforts of the Child Trauma Academy (a joint Texas Children's Hospital and Baylor College of Medicine Program),

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[29] CHDP exam forms are used to record the findings of the comprehensive screening exam that is required as a part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment program, known in California as CHDP.

[30] Encounter forms are completed by medical providers at the time of any non-CHDP visit to the provider. These forms describe current health problems, necessary treatment, or referral.

Texas has developed a multi-domain assessment of families and children in the care of Child Protective Services (CPS).[31] The goal of this project was to develop early identification mechanisms for high-risk infants and children entering the CPS system. The assessment process consists of three components: family, developmental, and psychological evaluations, which are conducted by trained and certified community clinicians. Assessments typically take place within a few weeks of the time a child enters CPS custody.

The project's information management component, known as the Web-based Assessment Tool (WBAT), was created to enable key members of a child's treatment team to share information through a central data repository accessible via the Internet. The Web-based Assessment Tool allows a child's caseworker and any evaluating or treating clinicians to open the child's treatment record, add information about the child, share information with other providers, and review comprehensive assessment information. Only authorized individuals have access to the secure Web site, and only individuals with appropriate consents have access to any individual child or family record. This may include a child's caseworker, the caseworker's supervisor, evaluating clinicians, authorized service providers, the judge, and the child's attorney.

As a central repository for data about a child and his or her family, the Web-based Assessment Tool provides records-keeping, communication, and report-generation tools for authorized users. It provides the data necessary to better match placement and services for children in the care of CPS, thereby reducing time in out-of-home placements. The assessment and management information systems have helped to identify children who are in need of early intervention, to speed implementation of services, to retain records across various placements, and to avoid repeated assessments of children and families. Thus, it allows for more efficient and

cost-effective planning, delivery, and outcome evaluation of services.

The project was first piloted in Houston in 1996. After modifications it was incorporated into existing CPS systems in Austin and Harlingen. To date, the system has served more than 1,200 children and their families. Quantitative and qualitative information about the emotional, behavioral, cognitive, and physical status of more than 10,000 children will be available at the end of the 5-year pilot phase. Over the next few years, further improvements will be made as the process is taken to scale throughout Texas. ◆

■ Utilizing Health Care Data to Aid in Meeting Child Welfare System Goals

In this section, we discuss uses of health care data that go beyond managing an individual child's care. This includes examination of data as part of federal Child and Family Services Reviews, as well as aggregation of health care data across all children served.

■ Health care data and the Child and Family Services Review process

In March 2000, regulations went into effect for a new approach to federal oversight of state child welfare programs, known as the Child and Family Services Reviews (CFSR). Overseen by the Children's Bureau of the Administration for Children and Families (ACF), the review process consists of a statewide assessment as well as an on-site review, which is conducted by a team of Federal, State and peer reviewers. During the on-site review, the team conducts case record reviews and interviews community stakeholders as well as children and families receiving services. Information gathered during the reviews is used to examine states' success in meeting three major goals of the child welfare system—children's safety, permanency and well-being. One of the outcomes examined under the rubric of well-being is whether children receive adequate services to meet their physical and mental health needs. Specifically,

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[31] For more information on this approach, see the program's website: http://www.childtrauma.org/Core_Assess_fact_sheet.htm

reviewers look for evidence recorded in a child's case file to document whether the child has received: an initial health screening, preventive health and dental care, immunizations, treatment for identified health and dental needs, mental health screening or assessment, and treatment for identified mental health needs. Reviewers also examine the agency's method for tracking children's medical needs and services, as well as whether health records have been provided to foster parents.

Child and Family Services Reviews document areas of strength and areas needing improvement. States then have the opportunity to implement program improvement plans and to receive technical assistance in making the improvements.

■ Aggregating health care data

In addition to tracking health care data for individual children in foster care, the capacity to aggregate data across all children served is crucial. Data aggregation allows for:

• accountability;

• examination of system-level outcomes;

• identification of system-wide needs and gaps in services;

• compilation of a population-based description of health problems experienced by children in foster care;

• identification of emerging health issues;

• determination of whether children in care are receiving services according to national standards;

• provision of information to support policy development and program enhancement;

• examination of cross-system issues.

Many of the respondents in this study indicated that they had data that could be aggregated for analysis purposes. However, they often lacked the staffing and resources to do this.

The Fostering Healthy Children Program: Health Status Outcome Measures
State of Utah

The State of Utah has established a Child Welfare Health Care Advisory Committee, which includes representatives from Medicaid, the state child welfare and mental health agencies, the foster parent association, and the provider community. One of the issues the committee has addressed is the development of health status outcome measures based on national standards of care.[32] When children enter the child welfare system, public health nurses from the Fostering Healthy Children Program track their health history and health status.[33] Utilizing data from initial medical, dental and mental health assessments (expected to occur within 30 days of entering care), the nurses rate children's health status using six indicators:

1. Child is receiving routine screening and preventive care

2. Child has acute or chronic condition(s) and is receiving adequate care

3. Child needs to establish or update preventive services

4. Child has acute or chronic conditions and needs to establish or update services

5. Child has suspected or significant undiagnosed/untreated problems

6. Child's status cannot be determined from available information

Aggregate reports can be generated from this system. For example, Utah's Division of Child and Family Services (DCFS) produces an Outcome Measures Report that tracks outcomes for children in the agency's care according to national child welfare system goals of safety, permanency and well-being. One indicator of well-being that the state is tracking is the extent to which the physical, social and emotional needs of children in DCFS custody are being met. A measure of

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[32] Additional information may be found in Rawlings-Sekunda, J., H. Balken, L. Bannister, and K. Betts. *Efforts in Ensuring Health Care to Children in Foster Care: Case Studies of Nine States.* Portland, Maine: National Academy for State Health Policy, 1999.

[33] More information on the role of public health nurses in the Fostering Healthy Children program is presented in Chapter 6 of this document.

this outcome is the percentage of children who received initial dental examinations, health assessments and mental health assessments within 30 days of entering care. The state has set a performance goal of ensuring that these evaluations occur for at least 90 percent of children entering custody. In the 2001 Outcome Measures Report, it was noted that 95 percent of children ultimately received the required assessments, but significantly fewer received them within the specified 30-day time frame. A plan was presented to identify barriers contributing to disparities between the actual results and the performance goal. One aspect of this plan was a survey sent to foster parents by the Fostering Healthy Children Program to ask about barriers. Results from this survey will be utilized to develop strategies for completing physical, dental, and mental health assessments within the specified time frame.[34] ◆

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[34] The Division of Child and Family Services Outcome Measures Report for Fiscal Year 2001 is available at http://www.hsdcfs.utah.gov/PDF/fy01report.pdf

TOPICS FOR DISCUSSION

Addressing Confidentiality Issues Around the Electronic Sharing of Data

Confidentiality issues remain a sticking point for many efforts to computerize health care data and make it accessible to all those involved in a child's care. These issues are particularly prominent in light of recent HIPAA legislation (see below) and the emergence of Internet-based systems. Some of the strategies for addressing confidentiality issues discussed by respondents in this study include:

- incorporating multiple layers of password protection in the system;
- ensuring that the system architecture provides the degree of security required by state and federal regulations;
- obtaining stakeholder consensus (including birth parents, foster parents and youth) regarding who should have access to what information and determining what information providers need in order to treat a child;
- providing training for all stakeholders on confidentiality policies and procedures, including HIV protocols;
- providing different levels of information access based on signed releases (the system should have the ability to generate different versions of passports depending on the recipient of the information);
- seeking consultation from experts on the legal implications of state and federal privacy legislation and issues around entering data on mental health and substance abuse services, HIV test results, and pregnancy testing;
- developing a system with the capacity to secure individual data fields that contain sensitive information.

Implications of HIPAA

The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** (PL 104-191) has far-reaching implications for children's services systems and almost any organization that uses technology to manage health information related to billing or service delivery. While the act contains some reform provisions for health insurance coverage, it also includes "Administrative Simplification" provisions that impact healthcare agencies' information systems. These

TOPICS FOR DISCUSSION *continued*

provisions were intended to make electronic administrative records (including claims and encounter data) more efficient, secure, and private through standardization and regulation. The major areas to which the administrative simplification rules and standards apply include:

1. *Code sets for electronic transmission of health information.* Standard electronic formats must be adopted such that all health care providers use the same codes (including transactions related to claims, encounters, enrollment, eligibility, and payment). Currently, approximately 400 different formats exist for these codes, but HHS has selected codes that providers are now obligated to use to exchange information. Most importantly, the law stipulates that all local codes (used for Medicaid claims) be eliminated. Local codes are those that providers may use to bill for non-traditional services—sometimes these services may be unique to a particular state or county.

2. *Privacy and security standards.* As HIPAA regulates electronic codes to streamline the healthcare system, it also sets rules to protect the privacy of medical records. Under HIPAA, all covered agencies must maintain "reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of the information, protect against reasonably anticipated threats or hazards to the security or integrity of the information, and to protect against unauthorized disclosure of health information." To this degree, every agency must establish detailed privacy and security policies and procedures, appoint privacy and security officers, implement staff training, conduct regular audits, post regulations, and inform patients of the policies and their rights.

Effective Dates and Compliance Issues

Regulations for the *electronic transaction standards and code sets* became effective on October 16, 2000. All covered entities must comply by October 16, 2002. The final *privacy regulations* became effective on April 14, 2001. Most covered entities (with the exception of health plans with fewer than 50 participants) must comply by April 14, 2003. *Security regulations* have been issued in draft form, but HHS has not issued final regulations; therefore, no compliance date has been set.

For more information on HIPAA:

Final rules and regulations in full: http://aspe.hhs.gov/admnsimp/final/txfin00.htm

Summary of the final privacy regulations (HHS Fact Sheet):
http://www.hhs.gov/news/press/2000pres/00fsprivacy.html

CHAPTER 6

Coordination of Care

Discussed in this Chapter

Strategies that states and communities are implementing to:

- Create an organizational structure for providing health care coordination services for all children in foster care

- Develop health care coordination approaches for populations of children with special needs

- Fund health care coordination services

In this study, we defined the critical component *Coordination of Care* as follows:

> *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.*

A Note on Our Terminology

The terms care coordination and health care case management are sometimes used interchangeably in this chapter. In general, however, we use the terms to refer to activities that go beyond a medical model of case management, to incorporate attention to children's physical, dental, developmental and emotional needs. Another way that care coordination differs from some uses of medical case management is in its focus on facilitating access to care rather than on cost containment.[35] While care coordination is often associated with the population of children with special health care needs, the complex physical, emotional and developmental needs of children served in the foster care system make this a critical component of their care as well. Care coordination is linked to the activities discussed in Chapter 5 on managing health care data and information. Health history information is needed for the development of an appropriate health care plan, and data must be tracked to ensure that health care needs are being met. For these reasons, experts working on the development of health care standards for children in foster care sometimes discuss care coordination and data management under the broader term of *health care management*.[36]

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[35] Rosenbach, Margo, and Cheryl Young. *Care Coordination and Medicaid Managed Care: Emerging Issues for States and Managed Care Organizations.* Princeton, N.J.: Mathematica Policy Research, Inc., June 2000.

[36] Task Force on Health Care for Children in Foster Care. *Fostering Health: Health Care for Children in Foster Care.* Lake Success, NY: American Academy of Pediatrics, District II, NYS, 2001.

Strategies and Approaches

Child welfare systems around the country have structured health care coordination approaches in different ways, both within and external to the public child welfare agency. Some of the approaches described by respondents in this study include:

- Co-locating care coordinators (employed either by the child welfare or public health agency) at child welfare agency offices;

- Obtaining care coordination services from external organizations, through contractual relationships or managed care approaches;

- Providing care coordination through foster care clinics; and

- Providing care coordination for children in the care of private child welfare agencies.

In addition, some agencies have developed specialized care coordination approaches to address the needs of specific populations of children. These include:

- Children who are medically fragile;

- Very young children; or

- Children in need of mental health services.

The project descriptions that follow illustrate various ways to provide health care coordination. In most of these approaches, nurses (e.g., public health nurses, RNs, pediatric nurse practitioners) play a prominent role in care coordination activities. They are sometimes assisted by health clerks or health service workers.

■ Public health nurses co-located at child welfare offices

Child Health and Disability Prevention Foster Care Program
State of California (implemented by counties)

In California, several local counties have been co-locating public health nurses in child welfare offices for a number of years. Seeing the benefit of this, the California legislature passed a bill[37] in 1999 that directs the Department of Social Services to establish a program of public health nursing in the child welfare services program. This law states that counties shall use the services of foster care public health nurses who will coordinate health care services and serve as a liaison with health care professionals and other providers of health related services. The bill describes the duties of a public health nurse and indicates that funding for services provided by the nurses may be claimed under Title XIX (Medicaid) at an enhanced federal match rate for services delivered by skilled professional medical personnel. The law also states that the program shall be implemented only if federal financial participation, as provided under Title XIX, is available. Most counties in California now have public health nurses co-located at the child welfare agency.

Operating via interagency agreements, the nurses are housed at child welfare offices to work in a collaborative, interdisciplinary manner with social workers to address the health care needs of children in foster care. California has developed statewide guidelines for public health nurses who work in child welfare settings. Some of the basic duties of foster care public health nurses that are child-focused include:[38]

- advocating for the health care needs of the child;

- medical case planning and coordination;

  – assisting in obtaining timely comprehensive assessments for children

  – participating in the development of a health care plan for the child

  – expediting referrals for medical, dental, and mental health services

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[37] Assembly Bill No. 1111, Chapter 147, SEC. 38. Section 16501.3

[38] California Department of Health Services, Children's Medical Services Branch, Child Health and Disability Prevention Program. *California Statewide Guidelines for Public Health Nursing in Child Welfare Services.* 1999. See also: Institute for Research on Women and Families, California Foster Children's Health Project, *Code Blue: Health Services for Children in Foster Care.* Sacramento: Center for California Studies, California State University, March 1998.

– following children placed out of county to assure access to needed services

• serving as a resource to facilitate referrals to early intervention services, specialists, dentists, mental health providers, and other community programs;

• overseeing the creation of the computerized Health and Education Passport;

• medical education;

– interpreting medical reports for social work staff and the courts

– educating social workers, judges, foster parents, school nurses, and others about the health care needs of the child.

Public health nurses are funded as skilled professional medical personnel (SPMP) through the Child Health and Disability Prevention Program (CHDP), which is California's name for Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Funding is 25% local and 75% federal.◆

Fostering Healthy Children
State of Utah
Fostering Healthy Children is a statewide program in Utah that provides health care case management for all children in out-of-home placements. Public health nurses employed by the Department of Health are co-located at Division of Child and Family Services (DCFS) offices in all seven regions of the state. The program was first implemented in the Salt Lake City area, and then expanded statewide.

Public health nurses in the program ensure that every child receives an initial health screening, comprehensive medical, dental and mental health exams, and follow-up services. The nurses work with the child/family's primary care provider, or help to identify a medical home for the child if the child does not have one. They gather health history information and make sure that medical providers receive this information. They also provide training for child welfare workers and develop care provider resources.

The nurses utilize a computerized case management system to track each child's health care. This system is integrated with Utah's statewide automated child welfare information system (SACWIS), known as SAFE.

Funding sources for the Fostering Healthy Children program include federal EPSDT funds and a local match of state funds from the Department of Child and Family Services.◆

■ Contracting with organizations that provide care coordination services

HealthWorks of Illinois
Cook County, Illinois and State of Illinois
In Illinois, the Department of Human Services (DHS) contracts with local health departments and community-based medical case management agencies to provide medical case management services for children in foster care. DHS regional maternal and child health nurses provide oversight to all of the medical case management agencies through annual record reviews and biennial certification audits.

When the HealthWorks approach was initially developed, it provided medical case management for all children in state custody. Unfortunately, due to budget constraints, these services were scaled back, and now are provided through HealthWorks only for children under age six. Interim medical case management services are still provided to children of all ages for the first 45 days of state custody. After that, the Department of Child and Family Services social worker assumes the medical case management function for children six and older.

Medical case managers are responsible for:

• retrieving a child's previous health care history;

• compiling health care information and forwarding it to the child's primary care provider before the 21 day comprehensive health evaluation;

• ensuring that the child receives all appropriate medical treatment and follow-up;

- maintaining a medical record for each child;

- entering medical information on each child into the state health department's computerized data system;

- preparing the health care portion of each child's service plan for initial and biannual administrative case reviews conducted by the Department of Child and Family Services.

Medical case management services are funded through Medicaid. The rates are approximately $201 per year for children over 12 months, and $315 a year for infants. DHS' Bureau of Community Health Nursing funds and provides the maternal and child health nurses who monitor the case management agencies. ◆

Healthy Tomorrows
State of Rhode Island

The Healthy Tomorrows project is designed as a community-based, family-oriented care coordination project to ensure that children in foster care have consistent, timely and appropriate medical care. It is also designed to make sure that medical records follow the child in order to provide continuity of care from placement to placement. The project is operated through a contract with the Kent County Visiting Nurse Association, under the administration of the Rhode Island Department of Children, Youth and Families (DCYF). A 25-member steering committee, composed of representatives of related state agencies, medical care providers, and foster parents serves as an advisory and coordinating body for the project.

Children in foster care may be referred to Healthy Tomorrows by DCYF staff, the child's pediatrician, a specialty medical provider, the foster family, the child's school, or other community agency. Any child may be referred to the program, but typical health issues listed as reasons for referral include: incomplete medical records or information on immunizations, lack of a primary care physician, physical disability, learning or behavioral problems, drug exposure, or chronic medical condition.

Administratively, the project is staffed by a registered nurse, a resource specialist (foster/adoptive parent), and a project coordinator. At least one home visit, scheduled at the family's convenience, is provided by a registered nurse to assess what needs the foster child and foster family may have. The nurse works with the family toward the development of a care coordination plan. This plan identifies any medical, educational, or social service referrals that may be required. Healthy Tomorrows staff coordinate these referrals if necessary. The plan also outlines what past medical records have to be collected and if education and support to the foster family is needed. Finally, the care coordination plan identifies whether the child has a primary care physician. If not, Healthy Tomorrows staff will coordinate an initial appointment. This initial intake process may be repeated when the child transitions to a new home. Other services provided during ongoing placement include:

- home visits;

- periodic family contact/consultation;

- emergency family support;

- developmental monitoring;

- parenting support;

- rehabilitation services;

- referral to community providers;

- care coordination between/among community providers, pediatricians, others;

- ongoing monitoring of health status, with provision of preventive health services;

- management of chronic conditions.

This project was originally developed with a five-year Healthy Tomorrows grant from the federal Maternal and Child Health Bureau. It is currently funded by Department of Children, Youth and Families Title IV-B monies.[39] ◆

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[39] 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.

■ Health care management model implemented within a private child welfare agency

Abbott House Department of Clinical Services
Irvington, NY

Abbott House is a non-profit child welfare agency serving approximately 800 children in New York City and surrounding communities. The Department of Clinical Services at Abbott House is responsible for the monitoring and delivery of medical, dental and mental health care to all children placed in foster care through the agency. Abbott House operates a daily clinic, staffed by two RNs, one LPN[40] and a pediatrician, to provide pediatric care by appointment and on a walk-in basis. A dentist also provides services on site. Mental health services include assessments and treatment for children and families. The Department of Clinical Services (and its two branches—the Medical Division and the Mental Health Division) is administered by the Medical Director, who is a pediatrician and child psychiatrist. The Medical Division is managed by a health services coordinator, who is a registered nurse. The Mental Health Division is staffed by seven doctoral level psychologists and six part-time psychiatrists who have expertise in developmental, emotional and behavioral problems of children and adolescents, and the problems particular to children in foster care.

Abbott House utilizes a "Health Care Management" model to ensure that children receive high quality, accessible, comprehensive and coordinated health care, whether it is provided directly by the agency or in the community. The model specifies a set of responsibilities involving care coordination, communication and linkage, advocacy, quality assurance, and education, which are performed by the Abbott House nurses, pediatricians and mental health professionals. Health care management is considered essential to effective integration of the health and social services

provided through Abbott House. A nurse serves as the primary health care manager for each child. The agency's staff of medical and mental health professionals work together as a health care management team to ensure that medical and mental health services are provided in a child focused, family friendly manner. Clinical staff work closely with the agency's social service treatment team as well.

Currently, all employees in the Department of Clinical Services are funded through a Medicaid per diem that is paid to Abbott House to cover health care services for children in the agency's care. The New York State chapter of the American Academy of Pediatrics has been advocating for funds that would be designated specifically for health care coordination.◆

■ Coordination of care for children with special health care needs by a managed care organization

Special Kids/Special Care
Commonwealth of Massachusetts

Special Kids/Special Care is a model of care coordination for children with special health care needs being pilot tested by the Massachusetts Department of Social Services (DSS) in cooperation with the Division of Medical Assistance. Children selected for this program are enrolled in a managed care plan developed specifically for children with the most serious medical conditions. Neighborhood Health Plan/Community Medical Alliance serves as the managed care organization for the program. It has a great deal of flexibility in terms of purchasing services, including private duty nursing, durable medical equipment, mental health services, and developmental services. Most services are covered, with the exception of dental care.

Provision of care is based on a nurse practitioner model. Nurse practitioners in each region of the state, employed by Neighborhood Health Plan, serve as care

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[40] A severe nursing shortage in the New York City area has resulted in several additional nursing positions in the department being unfilled.

coordinators for up to 15-20 children. The nurse practitioners:

- visit the home when a child first enters the program;

- develop a health care plan for the child, which is kept in the foster home and given to nurses who answer a 24-hour hotline;

- authorize services for the child and serve as a point of entry into any other services provided by the managed care organization;

- maintain health care information for the child;

- communicate with other stakeholders involved with the child: foster parents, DSS caseworker, school nurses, doctors, courts, and home health agency staff;

- provide sick and well child visits in the home.

Within the Neighborhood Health Plan, each child has a primary care provider and any other existing specialists that agree to become part of the provider network. When a child first enters the program, the child's current providers are asked to join the network so that care continuity will be maintained. If a child changes placements, the managed care organization is responsible for developing a transitional medical plan. If the child is adopted, the adoptive parent has the option for the child to continue in the program.

Case Review Team meetings are held monthly, with attendees including DSS caseworkers and administrative staff, Neighborhood Health Plan nurse practitioners and administrative staff, and Division of Medical Assistance clinical and administrative staff. The Case Review Team focuses on a review of the medical and social needs of children enrolled in the pilot. A formal evaluation of the Special Kids/Special Care program is being conducted in collaboration with Boston Children's Hospital.

The costs of medical care for children served by this program are reimbursed by Medicaid. The basis of this approach was the development of a contract to purchase services for a group of children from a provider

through use of a capitated rate. A new (much higher) rate category was created for the program. The model for services to be included in the capitated rate was developed by an advisory committee that included foster parents, and is based on the types of assistance that children with serious medical conditions typically require. ◆

■ Coordination of mental health services for children in foster care

Assessment and Consultation Team
Riverside County, California

The Assessment and Consultation Team (ACT) was created through an interagency agreement between the Riverside County Department of Mental Health (DMH) and the Riverside County Department of Public Social Services (DPSS). In this approach, licensed mental health clinicians, employed by the Department of Mental Health, are out-stationed at child welfare offices throughout the county to facilitate obtaining coordinated, community-based mental health services for children receiving child welfare services. The intent of this approach is that children and families served by DPSS will have direct and quick access to an expanded range of mental health assessment and treatment services. By monitoring the quality and quantity of services provided, ACT clinicians help ensure the highest quality of therapy possible for each child. They also strive to maintain consistent mental health services, even if a child moves to a different area of the county. The consultation aspect of the approach is designed to support DPSS social workers in understanding mental health issues, what to expect from mental health services, and to interpret reports from therapists.

Out-stationed ACT clinicians provide:

- review and assessment of a child's need for mental health services;

- direct clinical assessment of children and families whose clinical needs are unclear;

- determination of treatment to be authorized;

- initial referral/authorization for mental health services (individual and family therapy, group services, psychological and psychiatric evaluation, and medication review);

- monitoring of the quality and quantity of services provided;

- routine review of mental health service treatment plans and authorization of extension requests from providers; and

- consultation services to social services workers regarding mental health issues related to the children served by the child welfare agency.

To fund the ACT clinician positions, the DPSS and the Department of Mental Health coordinated an application for administrative case management funding through Medi-Cal (California's Medicaid program). County social services departments may fund licensed clinicians meeting the designation of skilled professional medical personnel (SPMP). Through this funding source, the clinicians may provide selected activities "to help children who are Medi-Cal eligible, including children in foster care and children seriously emotionally disabled (SED), to gain access to health related services in order to reduce their risk of poor health outcome." DPSS was approved as the fiscal agent to receive the funds from Medi-Cal and is required to provide a 25% match to the total budget. If the clinicians were not licensed, the DPSS level of match would be 50%. The Department of Mental Health actually hires the ACT clinicians, but is reimbursed by DPSS for these costs.

Under this funding source, skilled professional medical personnel cannot provide direct treatment services. Individual providers, who have contracted with the county Department of Mental Health to be part of a provider network, bill the department for treatment services. The Department of Mental Health is responsible for paying providers for all reimbursable services and for billing Medi-Cal when allowable. DPSS reimburses the Department of Mental Health for all costs of services not reimbursed by other funding sources. ◆

Medicaid as a Funding Source for Health Care Coordination Services

States such as California are using two sources of Medicaid funding (administrative case management and targeted case management) to provide care coordination services for children in foster care.[41]

Administrative case management
Public health nurses and other clinicians who meet the designation of Skilled Professional Medical Personnel are being hired to conduct various activities claimable under Medicaid. The function codes for these activities include:

- 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

Targeted case management
Case management activities may be claimed as a service when they are based on an individual recipient and are for the purpose of linking an eligible individual with the most appropriate providers of care and services. Local health departments that have defined children in foster care as a target population needing assistance to access necessary services may be able to receive funding for targeted case management services.

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[41] California Department of Health Services, Children's Medical Services Branch, Child Health and Disability Prevention Program.

TOPICS FOR DISCUSSION

Deciding to Invest in Health Care Coordination

Because health care coordination services may represent a significant investment on the part of the child welfare agency or other child-serving agencies, the costs and benefits of a care coordination approach are important issues for discussion. One way of framing these discussions is to consider the role of care coordination in achieving the three major goals of the child welfare system—**safety, permanency, and well-being**.

1. Safety
How will health care coordinators:

☐ aid in obtaining and interpreting a thorough medical history for every child coming into care?

☐ provide everyone involved a clearer understanding of the child's health care needs and supports that must be in place to ensure the child's safety?

☐ serve as a resource to parents (birth, foster, adoptive) when they have questions about medical care?

☐ provide medical expertise to ensure that health care services are appropriate?

☐ understand how the child or family's culture affects attitudes and behaviors around health and illness?

2. Permanency
Will the health care coordination approach:

☐ assist the child welfare agency and the court system in making appropriate placement decisions?

☐ help to ensure that a health plan for each child is incorporated into the permanency plan?

☐ enhance reunification efforts by providing biological parents with a better understanding of their child's needs?

☐ lead to more successful placements and reduce placement disruptions?

3. Well-being
Will the health care coordination approach:

☐ help to ensure that every child receives appropriate screenings, assessments, and immunizations, and has a primary care provider in a medical home?

☐ ensure that the physical, developmental, and emotional needs of the child are addressed while in foster care?

☐ enhance the parent's capacity to provide for the child's needs?

☐ enhance communication between a child's health care providers, caseworkers, foster and birth families, thus allowing for more coordinated care?

☐ assist the child welfare agency in collecting data to track the overall health and well-being of children in care?

TOPICS FOR DISCUSSION *continued*

4. Additional questions to consider in developing an approach

☐ What type of system will be set up for communication between the health care coordinator(s) and caseworkers?

☐ Will the health care coordinator have direct access to a child's caregivers (birth, foster, or adoptive parents, legal guardians)?

☐ What qualifications should the care coordinator(s) have?

☐ What will be the role and expectations of the care coordinator(s)?

☐ What capacity will the care coordinator(s) have to authorize care?

☐ How will care be coordinated across systems (e.g., physical health, mental health, early intervention)?

APPENDIX A

Contact Information for Approaches

■ Arkansas

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■ California

Assessment and Consultation Team (ACT)
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Child Health and Disability Prevention Foster Care Program; Computerized Health and Education Passport
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Child Health and Disability Prevention Provider Unit
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Developmental Screening and Enhancement Program (DSEP)
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Donner School Clinic
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Services to Enhance Early Development (SEED)
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■ Colorado

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■ Connecticut

Health Care Advocacy Services
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■ Illinois

HealthWorks of Illinois
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■ Indiana

Medical Passport for Children with Special Health Care Needs
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ISDH—Integrated Services SPRANS Grant
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■ Massachusetts

Multidisciplinary Assessment Teams
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Special Kids/Special Care
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■ Michigan

Medical Passport
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■ Montana

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■ New York

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The Children's Aid Society/Mount Sinai Medical Center Collaboration
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ENHANCE Services for Children in Foster Care
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The Permanent Judicial Commission on Justice for Children
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St. Christopher's, Inc. Family Healthcare Network
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■ Ohio

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■ Pennsylvania

The Managed Care Unit
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The Starting Young Program
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■ Rhode Island

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■ Texas

Web-Based Assessment Tool
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■ Utah

Fostering Healthy Children
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■ Virginia

**Parent Educational Advocacy
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■ Washington

Foster Care Assessment Program
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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

Advisory Panel Members

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