

**CODE
BLUE**



Health Services for Children in Foster Care



**Institute for Research
on Women and Families**

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Dear Concerned Californian:

More than 100,000 of California's children are in foster care. Removed from their homes because of neglect or abuse, about 40-72 percent of foster children require ongoing medical treatment and 50-60 percent have moderate to severe mental health problems.

As wards of the state, children in foster care depend on government services for medical treatment.

But how well equipped is California to deal with the health needs of foster children? This is the question that members of the California Foster Children's Health Task Force have debated for the past six months.

Their diagnosis of the problem is disturbing. Foster children are not routinely assessed for medical, psychological or developmental conditions. Only a small pool of health care providers is willing to serve them, and Medi-Cal red tape and paperwork cause delays in treatment. As children are bounced from placement to placement, their medical records are poorly maintained or non-existent, placing them at considerable risk for over-immunization or misdiagnosis.

Why are health care services inadequate for foster children? The task force determined that there is no *system* of health care for foster children, but rather an unplanned, often uncoordinated set of services.

The task force strongly recommends that the Legislature and the Governor launch a multi-year planning process to create a planned, statewide system of health care for foster children. This system of care should be designed to adhere to a set of "guiding principles" that the task force presents in this report. There are also immediate steps that should be taken to improve the availability and adequacy of health care for foster children.

Devising a system of health care for children in foster care is a daunting assignment. It involves the combined expertise of professionals in child protective services, mental health, medicine, dentistry, the criminal justice system, social work and more. It requires providers at both the local and state levels to work together — putting the needs of the child above competition for resources and jurisdictional disputes.

This spirit of collaboration has typified the work of the task force, which the Institute for Research on Women and Families has been proud to sponsor. The task force members have our gratitude for their hard work and "out-of-the-box" thinking.

We also thank The California Wellness Foundation and The David and Lucile Packard Foundation for their support of the California Foster Children's Health Project. Terri Carbaugh, the project coordinator, and Linda Burden, the policy consultant, deserve heartfelt thanks for their long hours and constant dedication. The entire effort would not have been launched without the inspiration of Joyce Iseri, Laurie Soman, Rebecca Carabez, Carol Brown, Assemblywoman Dion Aroner, and Dr. Maridee Gregory. Ms. Soman, Dr. Neal Kaufman, Irene Ibarra and Carol Brown deserve particular thanks for their conceptualization of the recommended statewide system of health care for foster children.

But good ideas, collaboration and dedication will go for naught if there is not the political will to respond to the needs of foster children, particularly when what is needed is system reform.

There could not be a greater need for action — the health system for foster children is *code blue* — in dire need of reviving.

We hope that the analyses and recommendations in this report assist policymakers to take decisive action — and to work collaboratively to improve health services for children who have only the state to turn to for care.

Sincerely,

A handwritten signature in cursive script that reads "Kate Karpilow".

Kate Karpilow, Ph.D.
Executive Director

Executive Summary & Introduction

David,* a nine year-old boy, lives in a foster home 400 miles from his home county. David has significant hearing problems, but his foster parents have been unable to find a specialist willing to see patients with a Medi-Cal health plan from another county. It takes David's foster mother six months to secure an appointment with an audiologist. She is so frustrated by her efforts to obtain health care services, she may not accept another child into her foster home. David's brother may be turned away.

Children in the Foster Care System Have Overwhelming Health and Emotional Needs

Children and adolescents in foster care typically suffer serious health, emotional and developmental problems. As wards of the state, foster children are dependent on government-funded health services to respond to their often complicated health conditions. As of March 1997, approximately 110,000 children were in California's child protective system — a number that has doubled in the last decade.

As a group, children in foster care suffer high rates of serious physical or psychological problems compared with other children from the same socioeconomic backgrounds. Nearly 50 percent suffer from chronic conditions such as asthma, cognitive abnormalities, visual and auditory problems, dental decay and malnutrition, as well as birth defects, developmental delays or emotional and behavioral problems. Approximately 40-72 percent require ongoing medical treatment, and studies indicate that 50-60 percent have moderate to severe mental health problems. The cause of these conditions are multiple and stem from exposure to alcohol and drugs, lack of medical care, poor parenting, domestic violence, neglect, and unstable living conditions prior to family removal. The trauma of family separation, frequent moves and the stress and disruptions brought about by impermanent placements in the foster care system compound these conditions. Given their overwhelming and complex needs, foster children require and use health services more than other children.

* not his real name

Numerous Obstacles Limit Health Care

Despite extreme need, children and youth in foster care often fail to receive preventive and consistent health services due to inadequate medical records and limited access to care. Foster children rarely enter the system with useful health records or mental health histories; and access to full documentation is restricted by confidentiality issues, bureaucratic requirements or limited parental knowledge and unavailability. Burdened by heavy workloads, social workers frequently lack time and training to track elusive health data. A child's repeated moves in and out of child protective services further limit the quality of health information available for health assessment, diagnosis or treatment. As a result, pre-existing conditions are frequently overlooked; and health problems grow more acute as children move from placement to placement.

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Lack of access to care, caused by a fragmented and under-financed health delivery system, is the greatest health problem facing children in foster care. Given restrictions on covered services, low reimbursement rates, delays in payment and complicated billing systems, the number of providers accepting Medi-Cal is not sufficient. Health care resources over the past decade have not kept pace with the growth of foster care children, making provider availability even more problematic. Current restructuring of Medi-Cal from fee-for-service to managed care only exacerbates these obstacles.

Medi-Cal Managed Care Adds Complications

Federal law recently prohibited the *mandatory* enrollment of foster children in Medi-Cal managed care plans. However, counties with county organized health systems (COHS) have federal waivers that exempt them from this federal prohibition. In these counties, there is still mandated enrollment of foster children into managed care plans. Children in other counties, however, can only be *voluntarily* enrolled into Medi-Cal managed care plans.

What are the impacts of county-based, Medi-Cal managed care on health services for foster children? As the system is now structured, there is a major flaw that limits access.

Medi-Cal managed care is typically organized to serve children and families who stay in one place and see one provider. In contrast, children in foster care are highly mobile, frequently moving in and out of the system or among relatives, group homes and foster families. Many children (25 percent) move as many as three to four times a year, and county providers throughout the state depend on out-of-county placement to secure homes for 30 percent of the state's children in foster care (although some counties report higher figures). In short, the frequent mobility of foster children among counties makes it difficult for them to access health care when placed outside their county of origin.

Table 1 on this page summarizes problems, including those relating to inter-county transfer, that limit the delivery or impair the quality of preventive and treatment services for foster children.

Table 1

Why Foster Children Don't Get Adequate Health Care

- Constant mobility of foster children impedes continuity of care.
- Medi-Cal cards are not always available immediately to children who require urgent services and are not universally accepted by physicians.
- Thorough screening and assessment does not always occur.
- Comprehensive care for this special needs population is not always available.
- Many physicians do not accept Medi-Cal patients, including foster children, because of red tape and low reimbursement rates.
- Foster care providers do not typically receive training on how to gain access to complex county-based health systems.
- Many health providers have not been trained to deal with the complex physical, mental, and developmental health issues faced by foster children.
- Social workers are typically overburdened with high case loads and lack medical training.
- Lack of adequate medical records often results in over-immunization and under-treatment of chronic conditions.
- Insufficient coordination among health care providers and agencies can limit access to and quality of services.

The California Foster Children’s Health Project

For the past six months, more than 30 of the state’s top experts on California’s foster care system have engaged in intense discussions and debates, working to develop recommendations to improve the delivery of health services to children in foster care.

Organized into four work groups, the task force met on a weekly or bi-weekly basis to:

- Develop a plan for a statewide *system* of care.
- Identify changes to the current patchwork of services to improve access.
- Define how services could be better integrated or coordinated.
- Develop recommendations for creating statewide standards of care.

The task force made seven over-arching recommendations, which are summarized in Table 2, including recommendations to design a *model system of health care* for children in foster care (see Table 3 on page 4). The task force also developed recommendations to “patch” the current set of services.

The remainder of this report elaborates upon the issues and analyses that generated each recommendation. Throughout the report, the term “health care” refers to physical, mental, developmental and dental care.

Table 2

Task Force Recommendations

- Develop a system of health care for children in foster care.
- Provide a comprehensive benefit package and ensure timely screens and assessments for foster children.
- Improve coordination and delivery of services in counties.
- Hire foster care public health nurses.
- Cut red-tape in the Medi-Cal eligibility process.
- Increase the pool of providers by reducing barriers to participation.
- Increase training and education for foster and health care providers.

“Children in foster care are some of the most vulnerable children we can imagine — abused, neglected and abandoned. They’re now in the care of the state, and it has the responsibility of ensuring that these kids get the health care and other services they need.”

— **Laurie Soman, M.S.W.**

Senior Policy Analyst, Children’s Hospital Oakland

Project staff for the California Foster Children’s Health Project were responsible for translating task force committee and meeting minutes into a final report. Undoubtedly, there will be some translations that some task force members will applaud and others that may meet with disagreement. Together, however, the project staff and task force members join to present this report to stimulate thoughtful and forward-looking discussion and action to improve health services for children in foster care.

Table 3

A Model System of Health Care for Children in Foster Care

State Responsibilities

Quality Assurance

- Data analysis of population-based outcomes.
- Process and outcome evaluations.
- Technical assistance to plans and providers.



State Interagency Coordinating Council

- Adopt guiding principles.
- Ensure immediate and continuous Medi-Cal eligibility.
- Create a comprehensive health benefit package.
- Blend existing funding streams and identify additional resources.
- Increase provider pools by reducing barriers.
- Provide technical assistance to local systems of care.
- Provide training for all foster care providers and health care providers.
- Expand and systematize data collection.
- Conduct oversight, monitoring and evaluation.



County-Level Responsibilities

Local Delivery System

- Develop a unique health care plan for each child.
- Implement a needs-based referral process for assessments and treatments.
- Provide adequate and quality health services based on the child's needs.
- Provide a 72-hour health and/or medical evidentiary screen.
- Provide 30/60 day comprehensive assessments.



County Interagency Coordinating Council

- Assure that standards of care are being met by local providers.
- Identify, train and certify providers.
- Coordinate services throughout the county.
- Maintain a data base, including the creation and updating of a Health and Education Passport for each foster child.
- Oversight and evaluation of programs.

Develop a System of Health Care for Children in Foster Care

Problem Statement

Policymakers have not dealt effectively with the harsh realities confronting foster families and group homes trying to obtain health care for foster children. A system of health care for foster children has never been proactively designed, and no state entity has the singular authority to design a system or even make changes to improve or coordinate current services. Moreover, no state policy or guidelines exist to guide development of a system of care.

As a consequence, the state offers a confusing and often uncoordinated patchwork of programs to serve the health care needs of foster children. Health care providers and foster parents spend inordinate amounts of time trying to understand regulations and obtain care. Changes in placement for a foster child often trigger entirely new sets of providers and rules, beginning the bureaucratic cycle again and sometimes delaying critical health care for foster children.

Task Force Analysis

In researching and evaluating the available health services for foster children, the task force came to three significant realizations. *First, there has never been a pro-active, systematic effort to design a health care system for foster children.* In most cases, foster children have been “fit in” to existing programs, which almost always do not have the flexibility, resources or expertise to deal with the complex physical, mental, developmental and dental needs of children living without their parents.

Second, the task force determined that there is no agency or department within state government that has the authority to coordinate the multiple entities within the state that provide or regulate health services for foster children. While state law and regulations make the Department of Social Services ultimately responsible for accessing medical, developmental, dental and mental health care services for children in

out-of-home placement, the Department of Social Services must rely on existing county-based health care systems to serve foster children and does not have the authority to modify these systems to accommodate the needs of foster children.

Finally, the task force recognized that there is a need to create a coordinated, statewide system of care for children in foster care, but that this system would likely take on various forms within the 58 highly diverse counties that comprise California.

For example, some counties would utilize managed care, others fee-for-service, while some would develop a hybrid.

To design this flexible statewide system, the task force devised a set of “guiding principles” that can serve as decision-making criteria to develop a quality system of care responsive to the specific and complex needs of children in foster care. These criteria could also be used to guide decisions in the short-term as the current patchwork

of services is modified in the direction of the long-term vision (See Table 4 on page 6).

The task force also outlined the specific and necessary components of a statewide system (see Table 3 on page 4). These components include statewide standards of care, a comprehensive benefit package, presumptive and continuous Medi-Cal eligibility (with a universal access card), provider credentialing with adequate reimbursement of health professionals, and a statewide data-collection system.

The task force envisioned a State Interagency Coordinating Council, possibly under the auspices of the Health and Welfare Agency, to devise and implement policy, coordinate state departments, and monitor compliance with standards. Alternatively, some of these objectives could be accomplished by direct legislative action or intervention. The task force anticipated a three-to-five-year transition period to design and implement a coordinated statewide system of care for foster children.

“The foster care health system is really not a system at all. It is a piecemeal and disjointed set of departments that rarely communicate with one another about the best needs of the children they are charged with protecting.”

— Alan Watahara, Executive Director
California Children’s Lobby

Table 4

Guiding Principles to Create a Responsive Health Care System for Foster Children

The task force recommends that the state adopt guiding principles to steer development and implementation of a statewide system of care for children in foster care, whatever form that system might take. These principles should also guide decisions that would modify the current set of services.

The following principles are presented to launch discussion:

- **Adaptable** - The system must work in urban and rural counties, areas with or without managed care plans, and regions with or without a large supply of primary or specialty care providers. The system should be accessible to California's diverse populations, and provide services that are culturally sensitive.
- **Clear lines of responsibility and accountability** - A state and local governance system should be developed that clearly identifies who is responsible and accountable for the implementation and enforcement of the standards, procedures, guidelines, etc.
- **Minimum standards of care** - Statewide standards are necessary to ensure that appropriate care is provided on a consistent basis by all providers.
- **Statewide data system** - Information needs to be collected and recorded to reliably track the medical and other history of foster children, and this information needs to be available to providers regardless of county boundaries.
- **No disincentives for permanent placement** - In no case should a separate health care system for children in foster care act as a disincentive to permanent placement, whether placement is through family reunification or adoption.
- **Immediate and continuous eligibility for Medi-Cal** - Eligibility for Medi-Cal should be presumed upon physical removal of the child from the home, as well as for 12 months after the child has left the foster care system.
- **Consistent and individual health case management** - Each child should receive health care services based on their unique needs as identified in a care plan.
- **Comprehensive benefit package** - Foster children should receive benefits that are portable and available throughout the state.
- **Seamless care** - The system of health care should be seamless as the child moves into and out of foster care.
- **County-of-origin placements as a priority** - Every effort should be made to keep the child in his or her county of origin unless the child is being placed with relatives or the child's treatment needs suggest otherwise.
- **Access to providers** - The system should be designed to allow access to traditional safety-net providers.
- **Larger provider pool** - Incentives should be developed to increase the provider pool, including offering adequate provider payment for services rendered.
- **Quality assurance** - The system should be outcome- and performance-driven and meet quality-assurance measures. Providers and decision-makers should receive information on the quality of health care provided to foster children.

Recommendations

- **Refine and adopt *guiding principles*** to establish objectives for any health care system designed to serve the needs of foster children. See Table 4 on page 6 for the task force’s recommendations.
- **Enact key elements of an effective statewide health care system for foster children:**
 - Ensure immediate and continuous Medi-Cal eligibility, including a universal foster children’s health access card.
 - Create a comprehensive health benefit package, including standards of care.
 - Blend existing funding streams and identify additional resources.
 - Increase health service provider pools (physical, mental, developmental, and dental) by reducing barriers.
 - Provide technical assistance to local systems of care.
 - Provide training for all foster care providers and health care providers.
 - Expand and systematize data collection to inform program planning.
 - Conduct oversight, monitoring and evaluation for local and state entities responsible for the health care of foster children.

- **Establish, adequately fund and give cross-agency authority to a State Interagency Coordinating Council (SICC) to take on responsibility for designing and implementing the statewide system of health care for foster children, as well as implementing short-term measures to improve health services for foster children.**

The composition of the SICC should include, but not be limited to, representatives from the departments of Social Services, Health Services, Mental Health, Developmental Services, Education and Justice, all of which have responsibility to provide services to children in foster care.

The SICC would need statutory responsibility for the health care of children in out-of-home placement and statutory authority to implement appropriate changes in state agencies and departments in order to create a seamless system that eliminates duplicative services and excessive paperwork.

- **In accordance with federal law, continue to enroll children in foster care in managed care plans *only* on a voluntary basis.**
- **The statewide system will require a separate entity from the implementing agencies to perform independent quality assurance through:**
 - Data analysis of population-based outcomes.
 - Process and outcome evaluation.
 - Technical assistance to plans and providers.

“Foster care should help stop child abuse — not allow the wounds inflicted by abusive parents to fester and spread. We need a system of specialized and compassionate health care to help foster children heal.”

*— Dr. Neal Kaufman, Director
Primary Care Pediatrics
Cedars-Sinai Medical Center*

Provide a Comprehensive Benefit Package

Problem Statement

State policy does not guarantee that children, when removed from their homes, will be fully screened or assessed in a timely manner for medical, psychological, developmental and dental conditions. And, though access to comprehensive health care services can aid in stabilizing placement decisions, comprehensive health care can be difficult to obtain or unavailable.

Task Force Analysis

The state needs to provide a comprehensive benefit package to ensure that foster children's physical, mental, developmental and dental health status is screened and assessed and that appropriate treatment is made available. Providing a comprehensive benefit package will also reduce the need for "treatment authorization requests" which frequently delay necessary health care services.

The American Academy of Pediatrics and the Child Welfare League of America both recommend screening of children following removal from the home. Foster parents also have emphatically urged that screens occur prior to placement to avoid exposing other children in their homes to contagious illnesses and conditions.

State law requires a 30-day Child Health and Disability Prevention (CHDP) examination, which primarily assesses the physical health of the child. The task force recommends that the state monitor compliance with this exam and that there be a more comprehensive assessment of the child's developmental and mental health conditions.

Recommendations

- **All children entering the foster care system should have an initial health screen prior to placement, but no later than 72 hours after detention.** The purpose of the screen is to identify health problems that would affect placement or require immediate medical, dental or mental health attention, including:
 - Contagious conditions — e.g., scabies, lice, chicken pox.
 - Acute illnesses or injuries — e.g., ear infections, gastroenteritis, dental abscesses, broken bones.
 - Physical disabilities — e.g., cerebral palsy, blindness, deafness.
 - Special medical needs — e.g., oxygen requirements, tube feedings.

- Chronic conditions — e.g., asthma, diabetes, seizures, schizophrenia.
- Suicidal tendencies.
- Other conditions as ascertained by a review of the child's medical history or medication record.

The brief, "72-hour screen" can be performed by a nurse practitioner or a public health nurse (PHN). Or it might easily be included in the assessment that occurs when a child is taken into custody following treatment at a hospital, clinic, or medical office. An augmentation in funding to county welfare departments would be necessary to compensate for increased demands on the case worker's time to schedule and transport the child to these screens.

- **The county needs to clarify with all providers that health services will be paid in a timely manner** — and that patients and their foster care providers are not to be billed.
- **Regulations should be adopted that require a mental health assessment to be initiated within 30 days of placement and completed within 60 days.**
- **The Legislature should direct the Legislative Analyst to evaluate the impact of the transition to consolidated mental health services on children in foster care and report back by January 2000.** Special attention should be given to the ability of the highly mobile foster children to receive services.

By April 1998, public fee-for-service Medi-Cal mental health care will be consolidated into fifty-eight county organized mental health managed care plans. With this change there will be one mental health system in each county to serve all Medi-Cal eligible beneficiaries who meet medical necessity criteria.

In some counties, there also exist Children's Systems of Care (CSOC) which serve severely emotionally disturbed children. CSOC are organized around guiding principles and values, utilizing interagency collaboration to include a broad array of services that are provided in a coordinated, cohesive manner. The state should consider requiring local mental health plans to provide assessment and evaluation services for foster youth through their local CSOC. In order to meet the needs of foster youth and expand services, the mental health system would need an appropriate augmentation in funding.

- **Services to foster youth should be improved by encouraging county departments of health services and mental health to co-locate mental health professionals in offices or clinics that serve large numbers of children in foster care.** This would be congruent with the counties' CSOC interagency approach.
- **Comprehensive and periodic developmental assessments should be conducted for children under six years of age. An educational evaluation should be done after a child enters school.** These assessments should be conducted by professionals knowledgeable about foster children's emotional, behavioral and developmental issues. Obtaining reliable results may take more than one visit to an experienced professional. Ideally, children under the age of five should be assessed at a multidisciplinary center simultaneously by both mental health and developmental professionals who, in coordination with other health care professionals, can generate integrated case plans.

The assessments, when required, should be initiated within 30 days of placement and completed within 60 days. Children should be reassessed according to need and in accordance with an age-appropriate schedule.

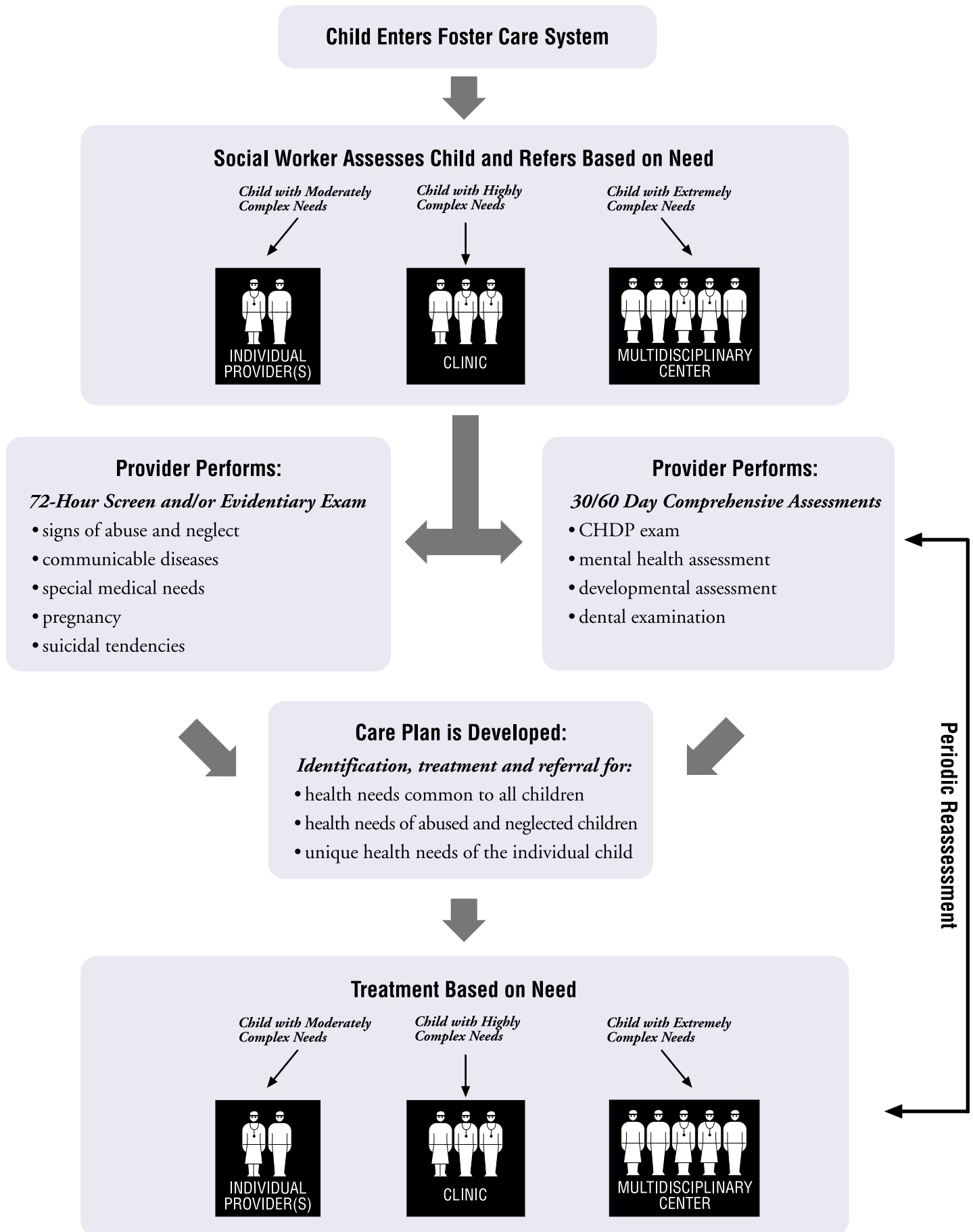
- **State policy that requires dental examinations to be completed within 30 days of placement should be clarified and reinforced by sending an all-county letter from the Department of Social Services.** Dental examinations are required at three years of age, or earlier for a suspected or identified dental problem. This examination needs to be performed by a dentist, preferably a pediatric dentist or a dentist experienced in treating children.
- **The departments of Health Services, Mental Health and Developmental Services should contract for the development of age-appropriate clinical guidelines and performance standard tools for each required screen and assessment.** These tools would be utilized by the examining physician.

“Let’s be honest, many of these children are removed because of parental neglect or abuse. Chances that they have scabies, lice or some contagious disease are high. Failure to immediately do a health screen means that other children might unnecessarily be infected or die of a treatable condition while in the custody of the state.”

— Dawn Beezk, Foster Parent

Table 5

Health Care Delivery System at the Local Level Treatment Based on Need



Improve Local Coordination and Delivery of Services

Problem Statement

County systems for assessing health needs and providing treatment for foster children are not organized to develop care plans for children that are based on the severity of the child's health status. Moreover, lack of coordination among the many service providers for foster children can negatively impact access to services, as well as the quality of service.

Task Force Analysis

There is a need to ensure systematic assessment and treatment of foster children that uses standardized assessment tools and directs children to treatment locations that best suit their needs. In addition, increased communication and coordination needs to occur among the various local entities involved in the foster children's health care.

Recommendations

➤ Reorganize the local delivery of health services to better assess and serve the needs of foster children.

The reorganized local service-delivery systems would ensure that all foster children entering care receive required screens and assessments and that subsequent treatment would be based on a unique care plan developed for each child and gauged to the level of need. Table 5 on page 10 diagrams the health care delivery system at the local level. In the system:

- All children would be referred to physicians to receive an initial medical evidentiary assessment and/or a 72-hour health screen, an expanded version of the 30-day CHDP exam (including comprehensive mental and developmental assessments), and primary care services designed to meet the child's unique needs.
- Age-specific standardized assessment instruments, forms and data collection techniques would be used for each required screen and assessment and for each level of child need.
- Each child would have a unique care plan created and approved by the courts that would address their age-appropriate needs, their needs due to neglect or abuse, and their unique needs.
- Thorough medical histories and the foster child's Health Passport would be maintained, and medical information would be recorded in the state's Child Welfare Services/Case Management Services (CWS/CMS) data base system.
- Assessment and treatment services would be provided by skilled providers in locations appropriate to the child's needs:

∞ *Moderately complex* health services would be provided in regular medical and mental health

offices and would include well child care, regular pediatric counseling, and routine care for illnesses. Some mental health counseling might also be required to deal with separation-related issues.

- ∞ *Highly complex* health services would be provided in offices or clinics where social services, pediatric specialty services, and/or mental health providers would be co-located or readily available for consultations.
- ∞ *Extremely complex* health assessments would occur at multidisciplinary centers where a team of professionals would evaluate the child to formulate a care plan. These centers would be linked to providers in the community and would be utilized by children with special needs, including those with significant medical problems, severe psychological problems, or learning disabilities and developmental delays.

Table 6 - Responsibilities of a County Interagency Coordinating Council

- Assure that standards of care are being met by local providers.
- Identify, train and certify providers.
- Coordinate services throughout the county.
- Maintain a data base, including the creation and updating of a Health and Education Passport for each foster child.
- Oversight and evaluation of programs.

➤ Develop County Interagency Coordinating Councils.

The task force recommends that each county establish a foster care health coordinating council which would meet at least quarterly to analyze health care problems faced by foster children and to implement solutions. Table 6 identifies the primary functions of the County Interagency Coordinating Councils.

A lead person or agency would need to be identified to head the council. In some counties, this would be the county health director or an existing committee. In small counties, where only one or two people are responsible for multiple tasks, a council might be unnecessary.

In each county, the task force envisions a memorandum of understanding (MOU) that would define responsibilities and accountability for county social services and all other involved parties (children's health services such as CHDP and California Children's Services, Medi-Cal managed care plans, mental and dental health). The MOU would set priorities, devise an implementation plan, and create a process to resolve future problems.

Hire Foster Care Public Health Nurses

Problem Statement

Over the past ten years, the number of children in foster care has increased dramatically — and the health conditions of foster children are typically complex. Studies indicate that 40-76 percent of children in foster care have chronic medical conditions, such as asthma, cognitive abnormalities, visual and auditory problems, dental decay, and poor nutritional state. The complex medical, mental health and developmental needs of foster children require intensive and expensive interventions, as well as case management and coordination of services among foster families, county departments and private providers. New mechanisms are needed to ensure that services are coordinated to serve the best interests of the child.

Task Force Analysis

Although legally responsible for the provision of health care, child welfare workers typically do not have the time to adequately coordinate the health care of children in foster care, nor do they have the training. In today's world, public health nurses (PHNs) with their health care knowledge and experience are necessary members of the child welfare team.

Foster care PHNs should be assigned to work with the team of child welfare workers and take responsibility for coordinating the children's physical, dental, mental and developmental health.

In each county, determining the number of foster care PHNs would depend on their assigned responsibilities, their access to clerical staff, and the county's population of children in foster care. An appropriate case ratio could be established for basic duties.

Recommendations

- **Foster care public health nurses should be assigned to county child welfare units to assist case workers with coordination of all health care services** (including physical, mental, developmental and dental) and to serve as contact persons for the health care community. The state should increase funding to county welfare units to allow implementation of this policy, which should be mandatory not optional. See Table 7 on this page for an expanded description of the Foster Care PHNs' responsibilities.

Table 7

Foster Care Public Health Nurse

The Foster Care PHNs' basic duties and responsibilities would include:

- Advocating for the health care needs of the child.
- Medical case planning and coordination:
 - ∞ Assisting foster parents in obtaining timely comprehensive assessments.
 - ∞ Participating with the assessment provider or center in developing a health care plan for children.
 - ∞ Expediting timely referrals for medical, dental and mental health services.
 - ∞ Following children placed out of county to assure access to needed services.
- Serving as a resource to facilitate referrals to early intervention providers, specialty providers, dentists, mental health providers, and other community programs.
- Overseeing the creation and updating of a Health and Education Passport as required by law.
- Medical Education
 - ∞ Interpreting medical reports for case workers and the courts.
 - ∞ Educating social workers, judges, foster care providers, school nurses, and others about the health care needs of the child.

Cut Red Tape in the Medi-Cal Eligibility Process

Problem Statement

Children in foster care are sometimes denied health services due to confusion about their Medi-Cal status. Even the 70-80 percent of children who enter the foster care system already on Medi-Cal can encounter problems. And the other 20-30 percent of youngsters who become eligible for Medi-Cal due to their entrance into the foster care system can experience delays of up to two months before receiving their Medi-Cal card. Many providers refuse to see children who do not have a Medi-Cal card in their possession.

Problems with Medi-Cal coverage occur when a child:

- Is eligible for Medi-Cal but has not yet received a Medi-Cal number and/or Benefits Identification Card.
- Is misdirected to a physician who is not his or her assigned primary care provider.
- Has been placed out of county, and out-of-county providers are unwilling to serve the child.
- Is in the system less time than it takes to establish eligibility.
- Has received service out of county, and there is confusion about the proper Medi-Cal billing procedures.

Task Force Analysis

The state needs to improve access to health care services for children removed from their homes by ensuring immediate health care coverage when a child is placed out of county, within the home county, and when the child leaves foster care and returns home. Both short-term solutions and longer-term structural changes are needed.

Recommendations

- **The state should pursue a policy of presumptive eligibility for the foster care population.**
- **Extend Medi-Cal eligibility for 12 months after a child has left the foster care system to ensure continuity of care.** This would reduce unnecessary paperwork and delay due to Medi-Cal enrollment and dis-enrollment that is triggered when a foster child enters or leaves the foster care system.
- **The departments of Social Services and Health Services should push for uniform practices in all counties to expeditiously qualify children entering the system who are not already on Medi-Cal.** An all-county letter should be sent to clarify laws and regulations and urge conforming practice:
 - Children entering the foster care system should immediately (upon removal from their homes) be issued a paper Medi-Cal card to ensure access to Medi-Cal services. Some providers will not schedule an appointment or see a patient without a card.
 - The Medi-Cal application process should be completed for all children removed from their homes regardless of the final placement outcome. This would allow for Medi-Cal billing for services provided to the child while in custody, even if the child is returned to his or her home.
 - The county of origin is responsible for the health care of a child in foster care — no matter where the child is placed. Sometimes dangerous disruptions in treatment regimes occur because of problems obtaining Medi-Cal coverage in the receiving county. Consequently, arrangements for health, dental and mental health care should be made in the receiving county prior to transferring the child from the county of origin. Furthermore, children changing placements should be accompanied by a copy of the child's Health and Education Passport and an appropriate supply of medications. If a psychotropic medication is being used, a copy of the last court order authorizing the use of this medication should be included with the drug.

Increase the Pool of Providers by Reducing Barriers to Participation

Problem Statement

There is an insufficient number of pediatric medical, dental and mental health providers who will accept Medi-Cal patients. There are even fewer providers willing to serve foster children because of the time and intensive services their complex conditions often require. Many practices are not equipped to handle the complex psychosocial and medical problems of children in foster care.

Task Force Analysis

Barriers need to be identified and eliminated that discourage providers from working with foster children. Current and potential providers need to be identified and supported.

Recommendations

➤ **Provide adequate and timely reimbursement for comprehensive services.** Mechanisms should be developed to adequately pay providers for the comprehensive services required by children in foster care. For example, providers should be paid an administrative fee for case management and to update the Health and Education Passport.

One practical mechanism for increasing payments in a capitated system has been adopted by The Alameda Alliance for Health. A risk-assessment tool that takes into consideration social factors as well as medical needs will be used to score children. Providers will be reimbursed by a monthly supplement for children identified as having special needs. This effort should be monitored to determine if it can eventually serve as a model payment program.

➤ **Use and expand existing state technology to ensure that adequate medical histories are available.**

- Expand use of the state's new computerized record-keeping system (CWS/CMS) to establish a centralized computerized medical record for each foster child. Medical information would be supplied to providers and caretakers on a need-to-know basis. Some counties already have experience with this system — San Diego, Orange, Riverside, and San Francisco.

- Make completion of medical records for the CWS/CMS system mandatory, not optional.
- Expand information collected on the CWS/CMS so it provides a complete health history.
- Provide funding to fully support county staff for creating and updating the medical record.

- **Provide referral support.** Foster care families and providers in offices lacking support from social workers or public health nurses often feel unable to deal with the complex psychosocial, developmental and mental health needs of children in foster care. Several approaches could increase referral support, including Foster Care PHNs, co-location of providers, or regional assessment centers.
- **Encourage and fund the creation of regional multi-disciplinary referral and assessment centers and teams throughout the state.** Foster children, foster parents, and local providers would benefit from multidisciplinary assessment and treatment centers. Providers could consult with the centers for advice or referral suggestions. Foster parents would have access to providers through the centers.
- **Ask counties to identify a list of pediatric medical, dental, developmental and mental health providers willing and experienced or trained in providing services to children in foster care. The name of a county contact person for each county list should be forwarded to the state.** The Department of Health Services should maintain a statewide resource list of the county contacts to assist social workers, foster parents, case managers, plan administrators, and health care providers in accessing local health care resources for foster children, especially those children who are placed outside their counties of origin.
- **Develop a process for giving local and statewide public recognition to providers serving children in foster care.**

Increase Training and Education for Foster and Health Care Providers

Problem Statement

Providers and caregivers have fragmented and incomplete information about the child welfare and Medi-Cal systems in their counties; the physical, mental, developmental and dental health care needs of children; and the special health care needs of children who have been abused and neglected.

Task Force Analysis

All parties involved in caring for foster children would benefit from health-related education and training programs. The task force expects that such training would result in better delivery and improved quality of health services.

Recommendation

➤ **The state departments of Social Services and Health Services (as well as the State Interagency Coordinating Council upon its creation) should work with provider and professional organizations to develop health-related training programs or components of existing curriculums for all providers of services to children in out-of-home placement.** This would include training and educational materials for case workers, caregivers (including kinship caregivers), and health care providers. Judges and defense attorneys need training on the need for timely court authorizations for medications and medical procedures. County administrative staff responsible for establishing Medi-Cal eligibility, paying medical bills, and approving “treatment authorization requests” also need training to understand their roles and responsibilities in the context of the entire child protective system. Table 8 identifies additional opportunities for training.

“Providing quality health care for foster children requires many people working together across traditional systems. We need to train people to work in these other systems so they can effectively serve foster children.”

*—Joyce Iseri, Executive Director
California Association of Children’s Homes*

Table 8

Opportunities for Training

- **Expand training of medical providers.**
Many providers are uncomfortable with children in foster care because they do not understand reporting requirements, the child welfare system, the legal system, and the need for court authorizations for some procedures. Training should be offered not only to pediatricians, but also to pediatric nurse practitioners, emergency room personnel, and family practice physicians. Courses can be added to residency training activities and fellowships.
 - The American Academy of Pediatrics should be encouraged to develop continuing education approaches on the special needs of children in foster care.
 - Multidisciplinary treatment centers should offer training in the unique needs of abused and neglected children and children in out-of-home placement.
- **Train foster parents and other caregivers.**
The Department of Social Services should develop curriculum for training foster families, foster family agencies and adoption agencies and include the following subject matter:
 - Requirements for medical, dental, and mental health services, including screens and assessments.
 - Information on county health care systems, including how to access medical, developmental, dental and mental health care.
 - Anticipatory guidance — the normal age-appropriate activities, speech, behavior, development and neurodevelopment of children.
 - Behaviors and emotions that require mental health interventions.
 - Safety and injury prevention.
 - Medical, dental and mental health procedures and prescriptions that require court authorization and the procedure for obtaining an authorization.
 - The importance of the Health and Education Passport.
 - The special health care needs of children in foster care.
 - The right of a foster parent to refuse to accept a child with special health care needs and the responsibilities if such a child is accepted.

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Opportunities for Training (continued)

➤ **Train county staff.**

Request that the departments of Social Services, Health Services, Developmental Services and Mental Health collaborate to develop a model health care curriculum about foster children's unique health care needs in order to train county staff responsible for placing foster children in temporary or permanent placements. In addition to the training recommendations identified for foster parents, the departments should include the following subject matter in the curriculum:

- Existing interagency protocols and MOUs.
- Information on the dental, mental and physical signs of abuse.
- How to work collaboratively with mandated reporters of child abuse.
- EPSDT (Early Periodic Screening Diagnosis and Treatment) and legal requirements regarding medical, dental, mental health and developmental exams for children in foster care and how to access care in the county of residence.
- The process and importance of securing Medi-Cal coverage in a timely manner.
- Procedures for obtaining health care services for a child placed out of county.

➤ **Train dentists on signs of abuse.**

This year, 1998, marks the first time that there are mandatory categories for the continuing education for dentists. The Office of Child Abuse Prevention (a unit of the Department of Social Services), the California Society of Pediatric Dentists, and the California Dental Association should be encouraged to include identification and reporting of the oral manifestations of child abuse in their dental continuing education requirements.

➤ **Train judges and defense attorneys.**

Judges and defense attorneys need to understand the importance of timely court authorizations for medical procedures and medications. This includes a brief description of the indications and types of psychotropic drugs.

Project Team

Kate Karpilow, Ph.D., is the Executive Director of the Institute for Research on Women and Families and the Project Director for the California Foster Children's Health Project. Ms. Karpilow previously served as the Executive Director for the non-partisan, statewide California Elected Women's Association for Education and Research (CEWAER) where she launched numerous public policy research efforts, including the California Women's Health Project, the California Children's Project and the Breast Cancer Outreach Project. She has professional experience both in the State Legislature and in local government. Ms. Karpilow received her Ph.D. from Harvard University in Social Psychology.

Terri M. Carbaugh is the Project Coordinator for the California Foster Children's Health Project. She brings more than a decade of experience in policy development, legislative strategy and media relations. She is experienced in bringing together diverse interests for the purpose of crafting issue-specific policy proposals.

Linda Burden, M.D., M.P.P., M.P.H., is a neonatologist who practices in Berkeley, California. Ms. Burden is the Policy Consultant for the California Foster Children's Health Project. She is the author of *Health Care for Children in Foster Care* and *The Transition to Medi-Cal Managed Care*. She is staff to the Child Health Policy Board of the California Partnership for Children (CPC) and a member of the Foster Care Policy Board. She represents the CPC on the Northern California Managed Care Task Force, a collaboration between managed care health plans, county welfare directors, CHDP foster care nurses and child advocates.

Jill Shannon, M.A., is the Research and Grants Coordinator for the Institute for Research on Women and Families and is the Evaluator for the California Foster Children's Health Project. She has directed a variety of research projects, including health and community assessments, program evaluations and organizational audits that have had policy impact and programmatic application. Over the past ten years, she has worked on a number of health issues, including child health and safety, health access, minority health, HIV-AIDS and mental health.

California Foster Children's Health Project Task Force

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Erin Aaberg, Consultant
Aaberg and Associates

Carol Brown, P.H.N., Deputy Director
City of Berkeley CHDP Program

Dawn Bzeek, Foster Parent

Catherine Camp, Executive Director
California Mental Health Directors Association

Rebecca Carabez, R.N., M.S.
CHDP Foster Care
San Francisco General Hospital

Valerie Early, Child Welfare Program Manager
Child Welfare Directors Association

Fran Edelstein, Ph.D., Deputy Director
California Association of Children's Homes

Jared Fine, D.D.S., Dental Health Administrator
Alameda County Public Health Department

Barbara Friedman, Director
Department of Public Policy
L. A. Care Health Plan

Neal Halfon, M.D., M.P.H., Professor and Director
UCLA Center for Healthier Children,
Families and Communities

Carol Hood, Executive Director
California Association of Services for Children

Irene M. Ibarra, JD, Chief Operating Officer
Alameda Alliance for Health

Joyce Iseri, Executive Director
California Association of Children's Homes

Neal Kaufman, M.D., Director
Primary Care Pediatrics
Cedars-Sinai Medical Center

Lee Kemper, M.P.A., Director of Policy
California Center for Health Improvement

Thomas Kubasak, Associate Director
California Association of Services for Children

Kathy Kuboda, Governmental Relations Director
Los Angeles County Department of Children
and Family Services

Sharon Leahy, P.H.N., Program Specialist
Los Angeles Department of Children and Family Services

Lana Miller, Ph.D., R.N., Nurse Consultant
San Francisco Children's Medical Services

Yolanda Partida, M.S.W., M.P.A., Representative
County Health Executive Association of California

Ruth Range, M.S., Child Health Consultant
California Partnership for Children/California
Children's Lobby

Kathy Skrabo, M.S.W., Director
Child and Family Center
California Institute for Mental Health

Laurie Soman, M.S.W., Senior Policy Analyst
Children's Hospital Oakland

John Takayma, M.D., M.P.H.
Assistant Professor of Pediatrics
University of California, San Francisco

Iantha Thompson, M.S.N., Program Manager
CHDP Program Merced County

Shannon Wilber, JD, Staff Attorney
Youth Law Center

Project Advisors

Patrick Ashby, Chief
Foster Care Branch
California Department of Social Services

Lou Del Gaudio, Manager
Placement Resources Unit
California Department of Social Services

Maridee Gregory, M.D., Chief
Children's Medical Services Branch
California Department of Health Services

Mary Lou Hickman, M.D., Medical Consultant
California Department of Developmental Services

Angeline Mrva, Chief
Medi-Cal Division Operations
California Department of Health Services

Linda O'Hanlon
Payments Systems Division
California Department of Health Services

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**Institute for Research on
Women and Families
c/o CSUS
6000 J Street
Sacramento, CA 95819-6081
phone - (916) 278-3793
fax - (916) 278-5199**

**Kate Karpilow, Ph.D.
Executive Director**



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**Institute for Research on Women and Families
California State University, Sacramento
6000 J Street
Sacramento, CA 95819-6081**

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