The Value of Leveraging Specialized Healthcare Services for Foster Youth

MARY GREINER, MD, MS

SARAH BEAL, PHD

Overview

- Discuss the health needs of children, including barriers to services with entry into PCSA custody and placement changes
- Describe healthcare service delivery models in Ohio and other states
- Identify strategies to access healthcare information and health services for CASAs
- Group discussion: Identifying healthcare needs and overcoming challenges

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Child protection in the US

1912 — US Children's Bureau
Limited intervention, congregate care

1935 — Social Security Act
Increased intervention, out-of-home care

1974 — Child Abuse Prevention Act

1997 — Adoption and Safe Families Act

2008 — Fostering Connections Act

2018 — Family First Act
Increased prevention, in-home care

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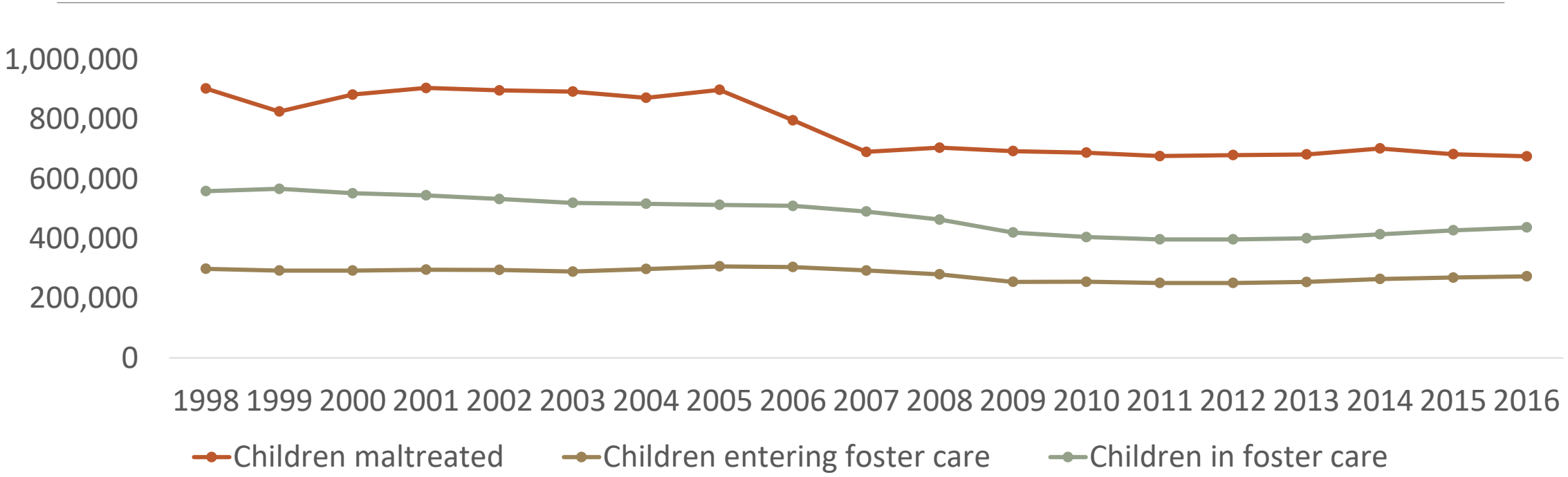
US child welfare involvement since 1998



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US child welfare involvement since 1998

SOURCE: Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2021 data[2]

Numbers at a Glance					
Fiscal Year	**2017**	**2018**	**2019**	**2020**	**2021**
Number in foster care on September 30 of the FY	436,556	437,337	426,325	407,318	391,098
Number entered foster care during the FY	270,197	263,776	252,414	216,842	206,812
Number exited foster care during the FY	248,882	252,209	249,936	224,425	214,971
Number served by the foster care system during the FY	685,403	689,505	676,188	631,686	606,031
Number waiting to be adopted on September 30 of the FY	124,004	126,546	123,823	117,446	113,589
Number waiting to be adopted for whom parental rights (for all living parents) were terminated as of the last day of the FY	69,921	71,990	71,887	63,836	64,985
Number adopted with public child welfare agency involvement during the FY	59,491	63,094	66,208	57,881	54,240

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Primary health concerns for children in protective custody

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Multiple mechanisms drive vulnerability

Genetic, Biological, and Environmental Risk

nature publishing group

Review

Children in nonparental care: health and social risks

Sarah J. Beal[1] and Mary V. Greiner[1]

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Multiple mechanisms drive vulnerability

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Multiple mechanisms drive vulnerability

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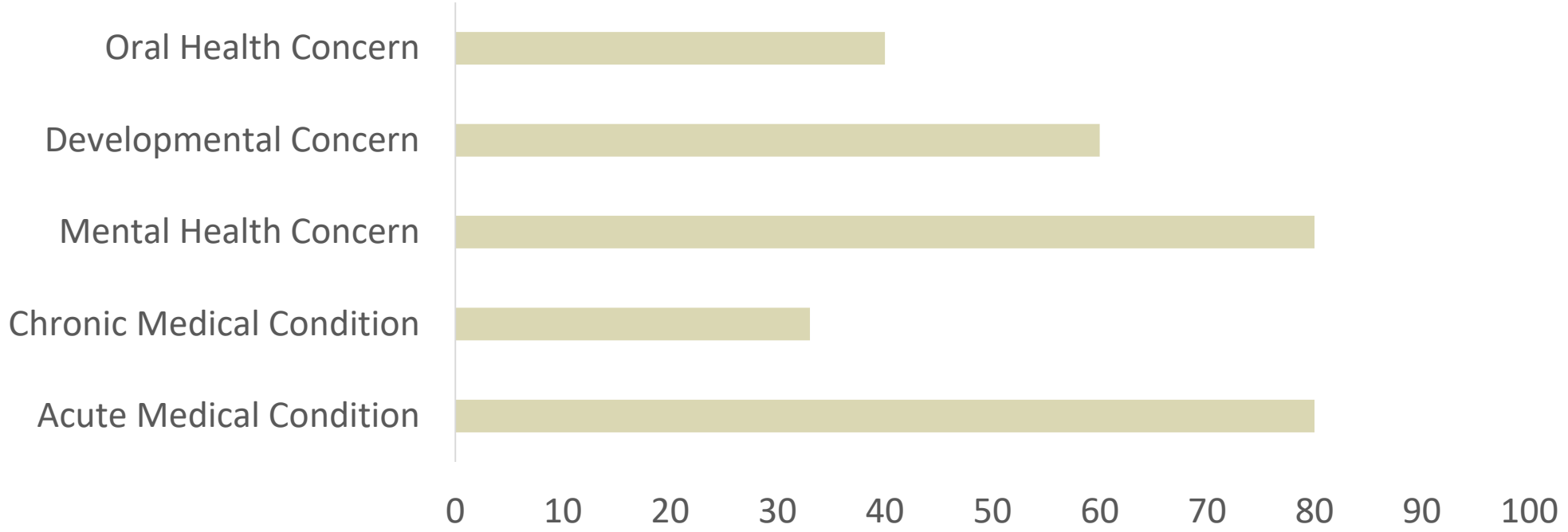
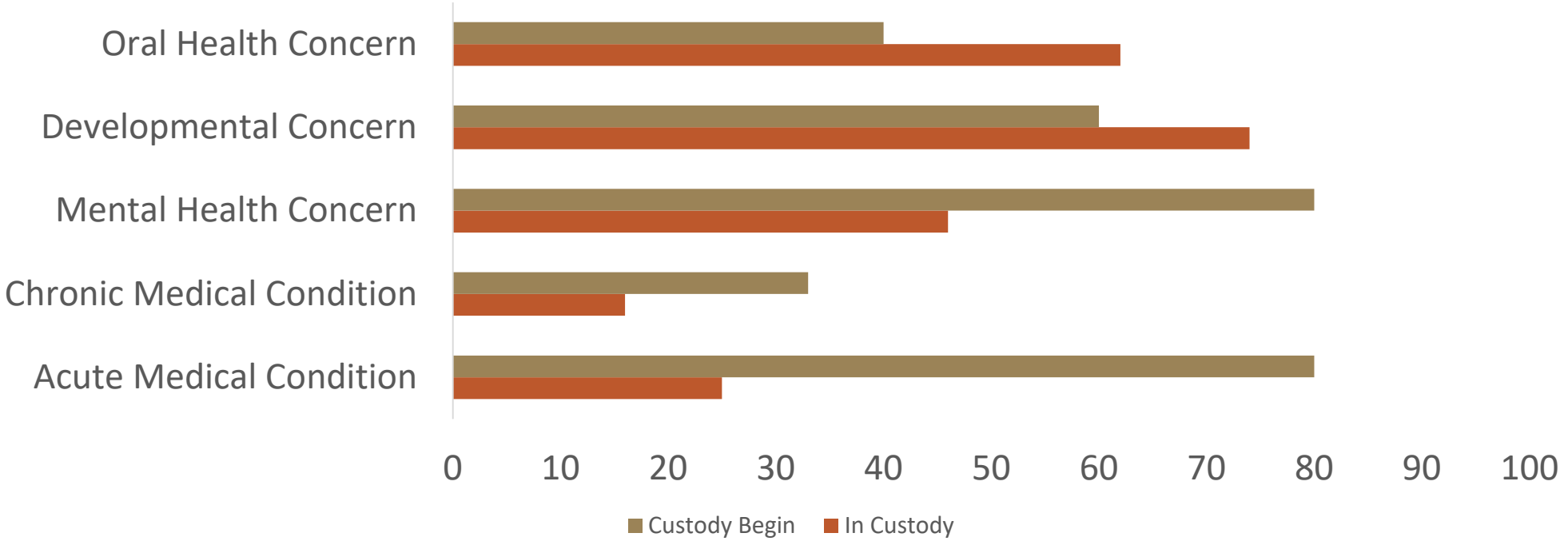
Health concerns common at PCSA start



AAP Report, *Pediatrics,* 2016

Health concerns continue during custody



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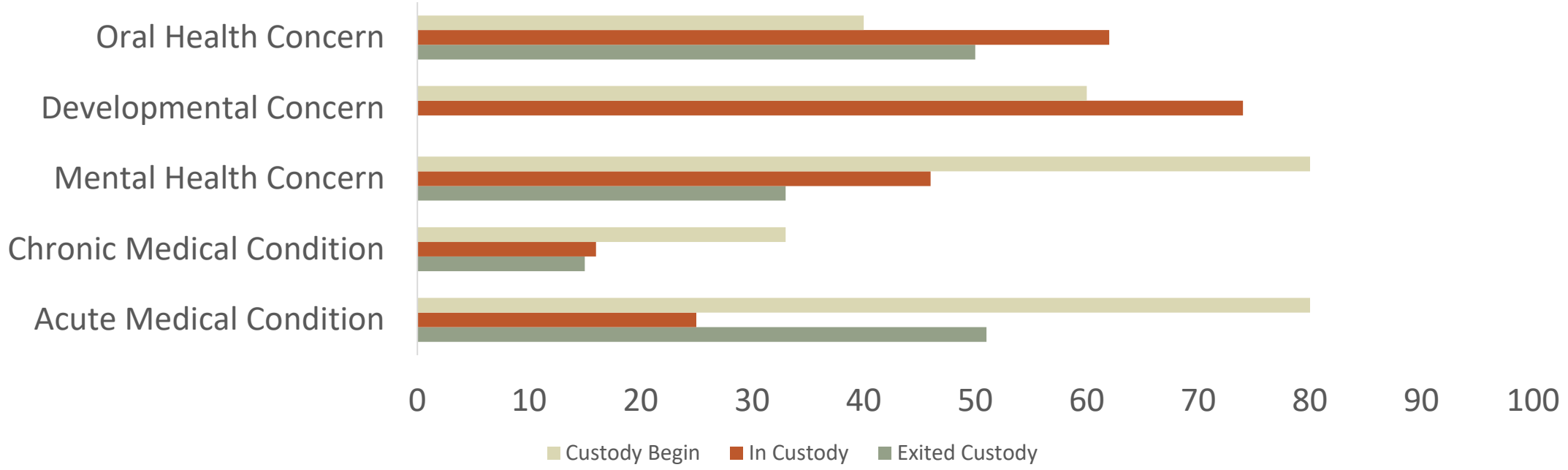
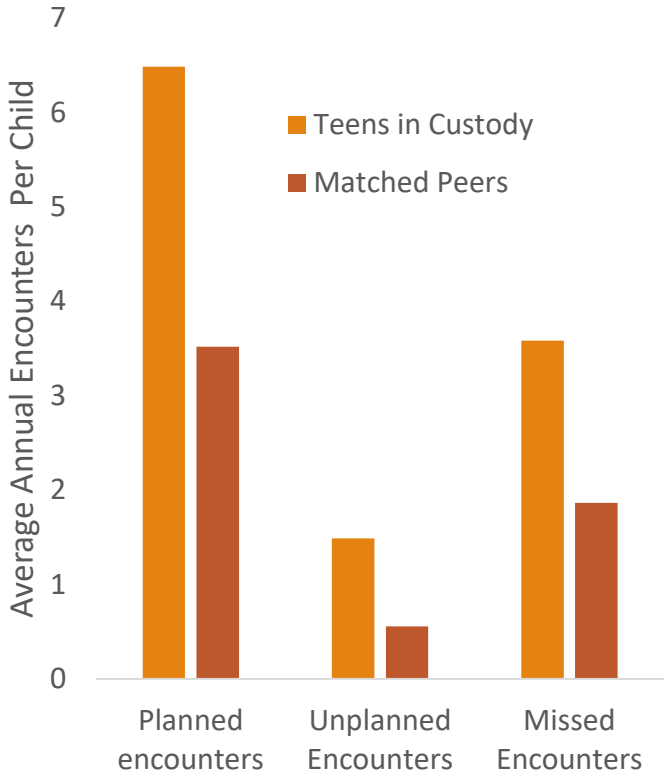
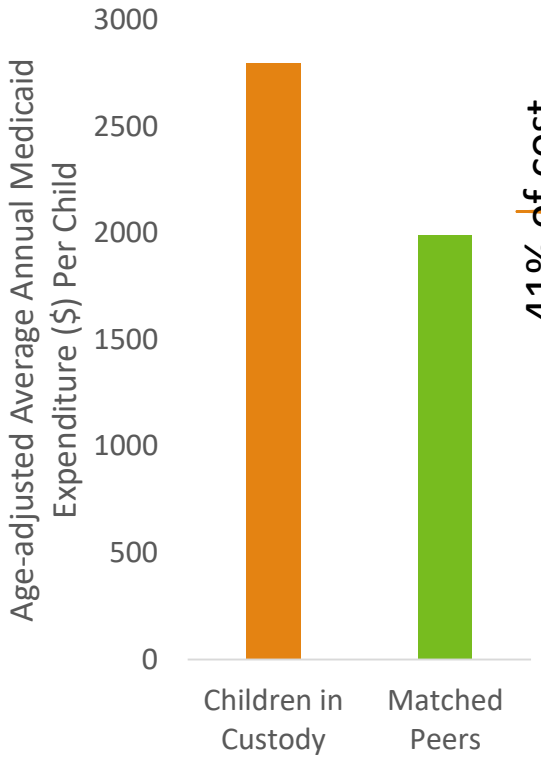
Health concerns persist to adulthood

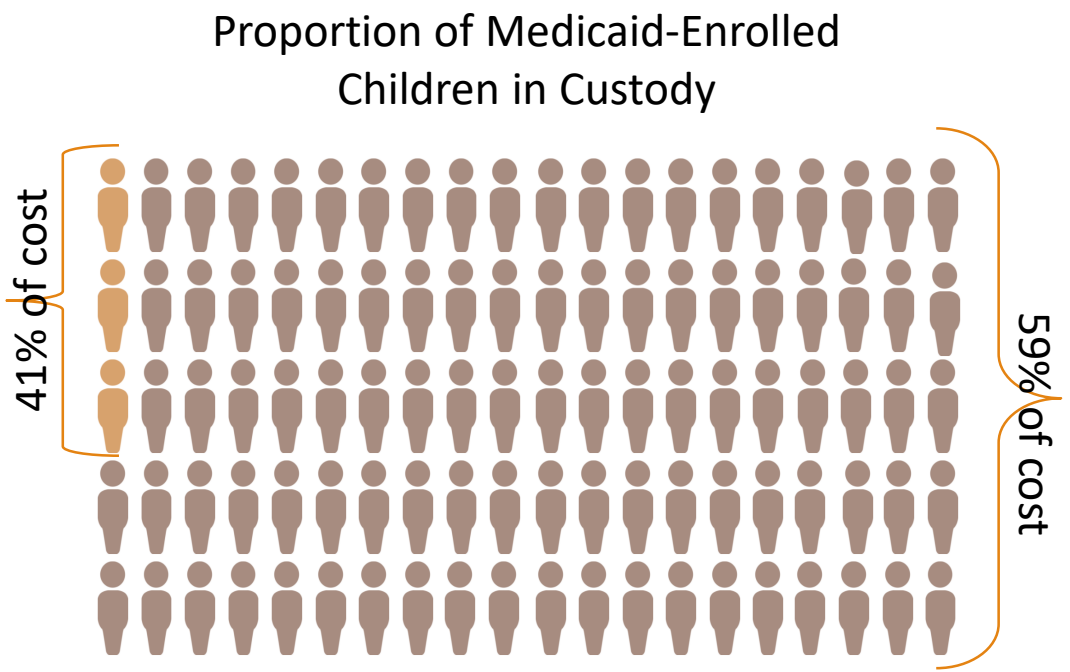


Midwest Study, 2011

Health burden leads to more care needs







How healthcare systems can help

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Guidance from AAP

- Early and often
- Initial screening < 72 hours
- Comprehensive evaluation < 30 days
- Enhanced visitation schedule

Healthy Foster Care America

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Guidance from the State

Rule 5101:2-42-66.1 | Comprehensive health care for children in placement.

Ohio Administrative Code / 5101:2 / Chapter 5101:2-42 | Substitute Care

(C) The PCSA or PCPA shall ensure a medical screening is completed within five working days of each child entering into substitute care or when a child's placement changes to prevent possible transmission of common childhood communicable diseases and to identify any symptoms of illness, injury, or maltreatment. A screening is not required for newborn children directly placed into substitute care from the hospital. The medical screening shall be conducted by one of the following:

(1) A licensed physician.

(2) An advanced practice nurse.

(3) A registered nurse.

(4) A licensed practical nurse.

(5) A physician's assistant.

(1) A comprehensive physical exam for children age three or over, including a review of physical, behavioral, developmental, vision, hearing and dental health is completed within sixty days after a child enters into substitute care. A comprehensive physical exam is not required if a comprehensive physical exam of the child has been conducted within six months prior to the child's entry into substitute care and a copy of the exam is filed in the child's case record. The agency shall ensure an annual comprehensive physical exam is completed no later than thirty days after the anniversary date of the child's last physical, which shall include a vision and hearing screening.

(2) Additional visits, as appropriate, should occur during the first sixty to ninety days of the child entering substitute care to:

(a) Assess the child in the process of transition;

(b) Monitor the adjustment to care;

(c) Identify evolving needs and;

(d) Continue information gathering.

Four justifications for specialization

Four justifications for specialization

Four justifications for specialization

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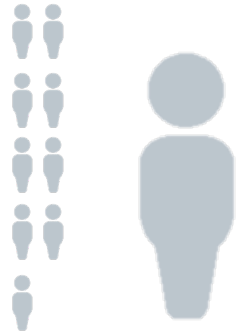
Four justifications for specialization



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6 Models of Healthcare Delivery

Needs and resources vary by community and multiple models have the potential for success

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Comprehensive Health Evaluations for Cincinnati's Kids (CHECK) Center

To optimize the wellbeing of all children and youth with and at risk for child welfare involvement, in the areas of medical, dental, developmental, and mental health from birth to transition to adulthood

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Development of the CHECK Center

Clinical Pediatrics
2015, Vol. 54(9) 853–861

DOI: 10.1177/0009922814563925
cpj.sagepub.com
SAGE

Foster Caregivers' Perspectives on the Medical Challenges of Children Placed in Their Care: Implications for Pediatricians Caring for Children in Foster Care

Mary V. Greiner, MD, MS[1], Jennifer Ross, BS[2], Courtney M. Brown, MD, MS[1], Sarah J. Beal, PhD[1], and Susan N. Sherman, PhD/DPA[2]

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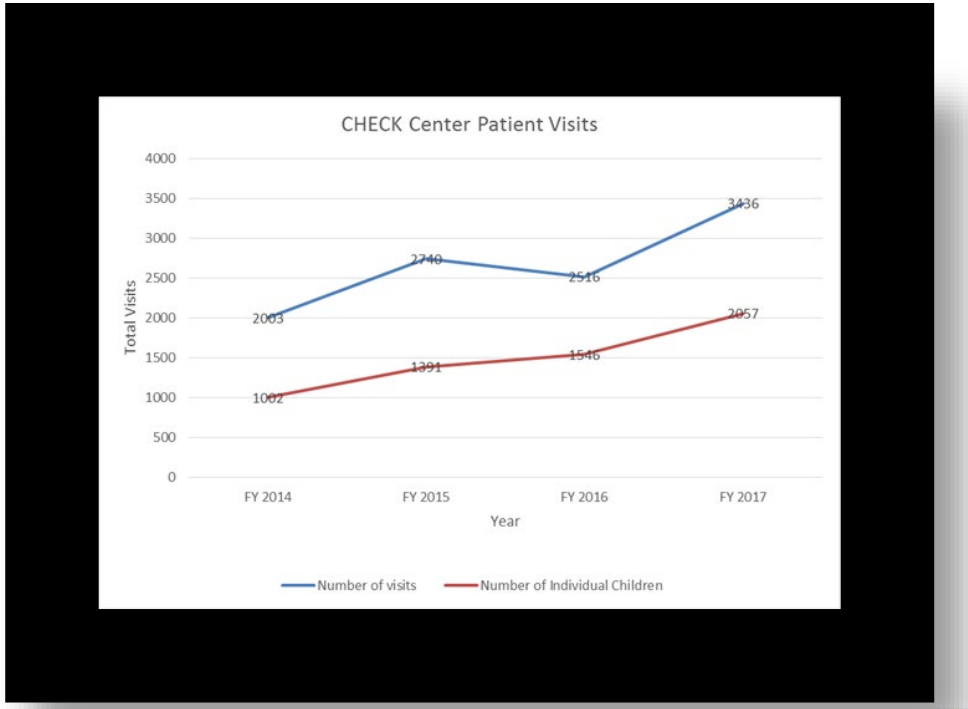
Development of the CHECK Center



Greiner, M. V., Nause, K., & Beal, S. J. (2023). The Use of Telehealth for Youth in Foster Care. *Clinical Pediatrics*, 00099228231161329.

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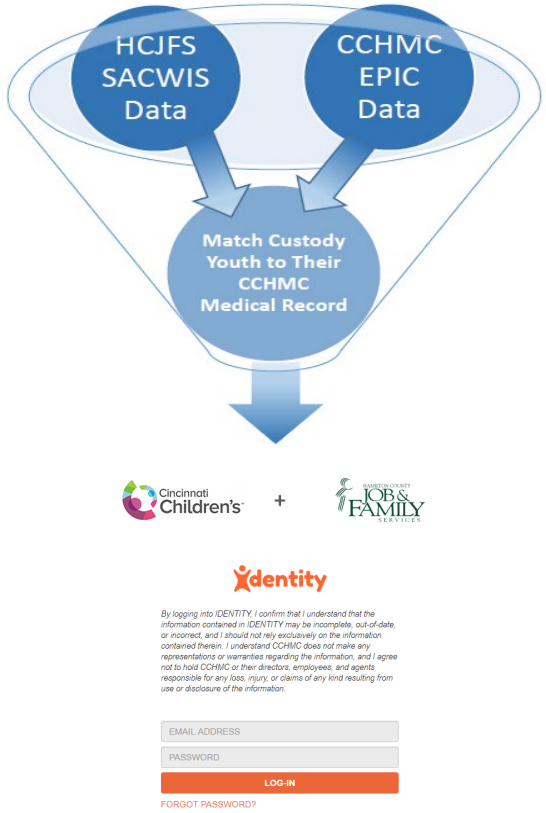
Supporting Access to Health Information



To address these barriers, we created an Integrated Data Environment to eNhance ouTcomes in cusTody Youth (IDENTITY)

IDENTITY shares near-real time information between social services and healthcare systems for children in protective custody

- Support communication between child welfare and healthcare providers
- Provide easy access to historical and current health information for new caregivers
- Enhance decision-making around healthcare and social services when children are in protective custody

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IDENTITY Implementation

March 2018: Pilot with 66 CPS staff, 10 clinicians

- Pilot testing and refinement with early adopters
- Train-the-trainer model to spread to all children's services staff, frequently used Cincinnati Children's Hospital clinics

July 2019: First implementation with 346 CPS staff, 284 hospital staff

June 2021: Second implementation with 467 CPS staff, 450 hospital staff

~3000 children represented in IDENTITY currently

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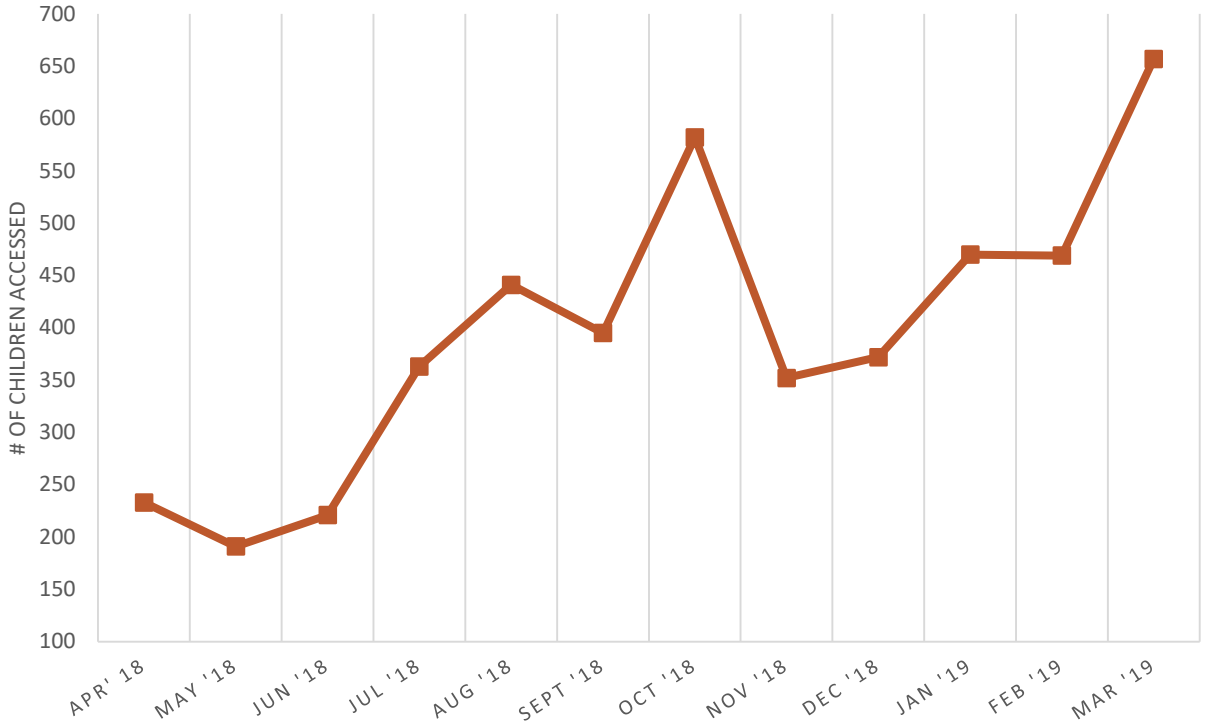
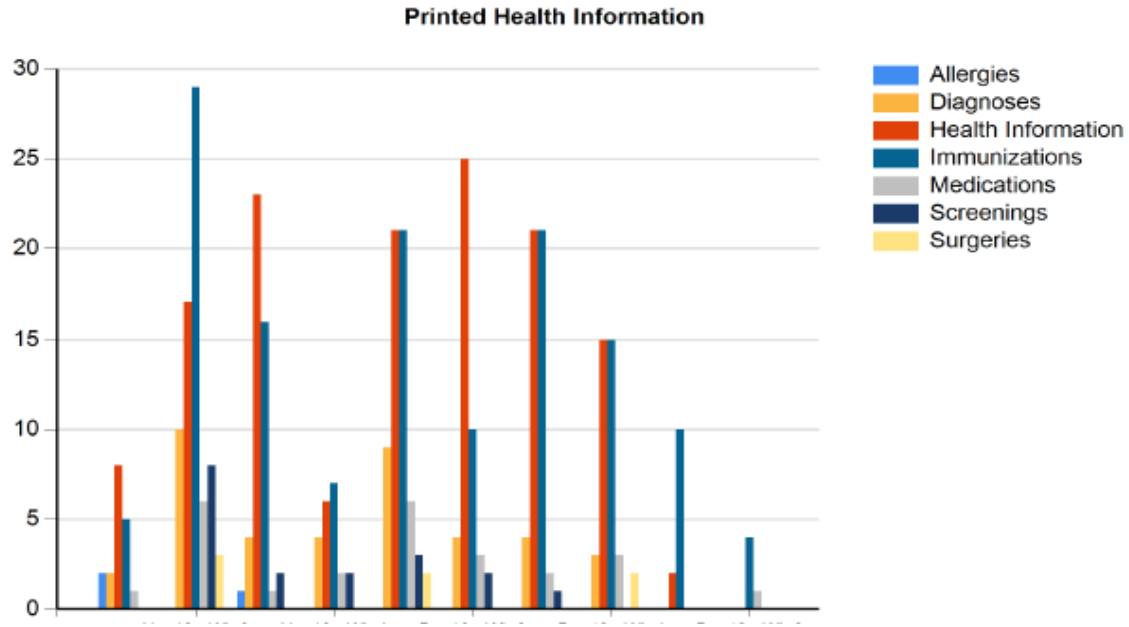
Caseworker and Child Welfare Impact





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Caseworker and Child Welfare Impact

Post IDENTITY Implementation:

- Youth available in IDENTITY within about 24 hours of entering custody
- Access to critical health information on-demand
- Organized so it is easy to find needed health care information
- Saving ~1.5 hours per child on a caseload

Caseworker and Child Welfare Impact

Themes from Qualitative Interviews

Providing more complete medical history when referring children for placement, alerting potential caregivers to what will be involved when caring for this child

Printing Immunizations required for school enrollment, cuts down wait time for youth to start school

Coordination with substitute caregivers to ensure youth are receiving recommended care, have their medications, attend scheduled appointments, etc.

For PC'ed youth, identifying prior Primary Care Providers to request all medical records in preparation to transfer to Adoptions

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Healthcare System Impact

Knowledge of foster care status

- Flag alerting hospital staff about child's custody status
- Accurate information about where a child is placed and who caregivers are

Information gathering

- 38 minutes in information gathering saved per new patient seen at a foster care clinic
- More complete and accurate information regarding child welfare history, custody status
- Increased recuperated Medicaid payments resulting from accurate billing information

Better healthcare

- 40% increase in compliance with mandated change of placement exams
- Increased primary care, less duplicated care

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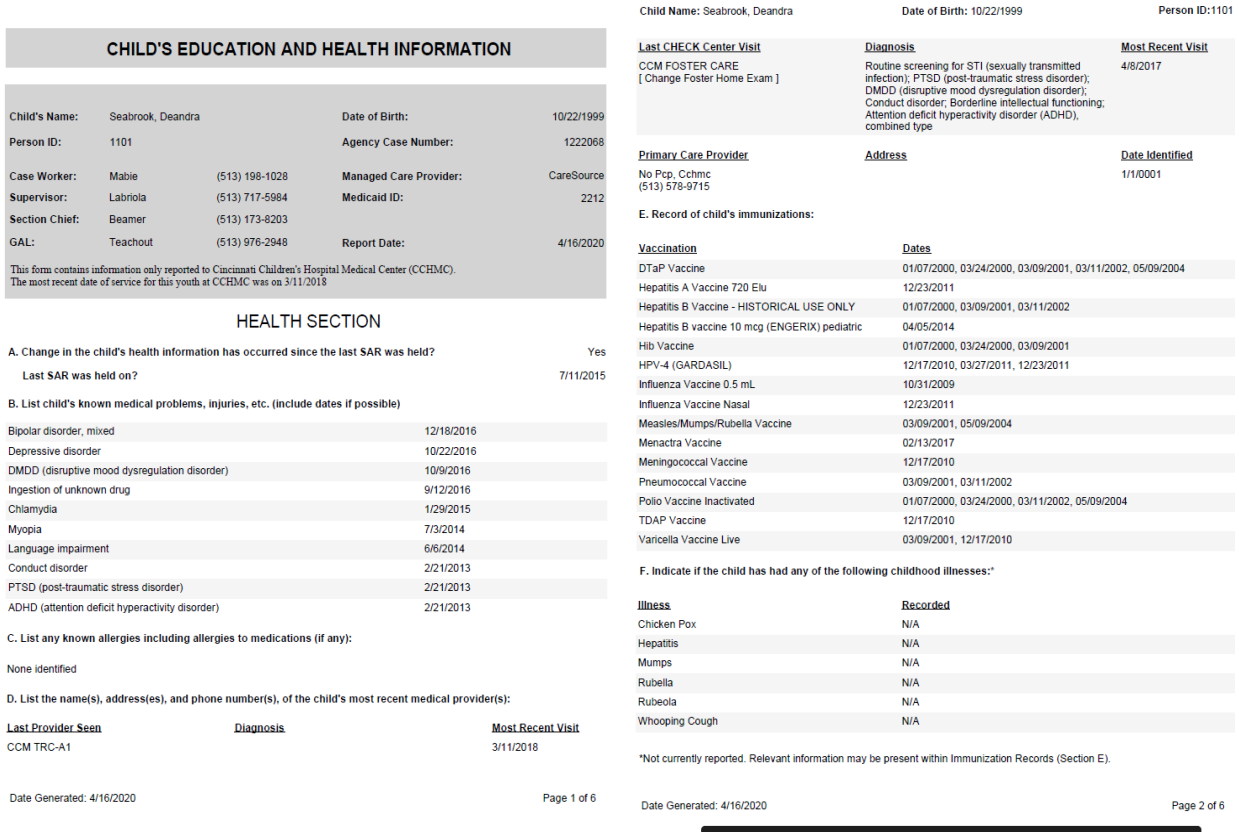
Enhanced Documentation Quality



CHILD'S EDUCATION AND HEALTH INFORMATION

Child's Name:	Seabrook, Deandra		**Date of Birth:**	10/22/1999
Person ID:	1101		**Agency Case Number:**	1222068
Case Worker:	Mabie	(513) 198-1028	**Managed Care Provider:**	CareSource
Supervisor:	Labriola	(513) 717-5984	**Medicaid ID:**	2212
Section Chief:	Beamer	(513) 173-8203		
GAL:	Teachout	(513) 976-2948	**Report Date:**	4/16/2020

This form contains information only reported to Cincinnati Children's Hospital Medical Center (CCHMC).
The most recent date of service for this youth at CCHMC was on 3/11/2018

HEALTH SECTION

A. Change in the child's health information has occurred since the last SAR was held? Yes

Last SAR was held on? 7/11/2015

B. List child's known medical problems, injuries, etc. (include dates if possible)

Bipolar disorder, mixed	12/18/2016
Depressive disorder	10/22/2016
DMDD (disruptive mood dysregulation disorder)	10/9/2016
Ingestion of unknown drug	9/12/2016
Chlamydia	1/29/2015
Myopia	7/3/2014
Language impairment	6/6/2014
Conduct disorder	2/21/2013
PTSD (post-traumatic stress disorder)	2/21/2013
ADHD (attention deficit hyperactivity disorder)	2/21/2013

C. List any known allergies including allergies to medications (if any):

None identified

D. List the name(s), address(es), and phone number(s), of the child's most recent medical provider(s):

Last Provider Seen	Diagnosis	Most Recent Visit
CCM TRC-A1		3/11/2018

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Child Name: Seabrook, Deandra **Date of Birth:** 10/22/1999 **Person ID:**1101

Last CHECK Center Visit	Diagnosis	Most Recent Visit
CCM FOSTER CARE [Change Foster Home Exam]	Routine screening for STI (sexually transmitted infection); PTSD (post-traumatic stress disorder); DMDD (disruptive mood dysregulation disorder); Conduct disorder; Borderline intellectual functioning; Attention deficit hyperactivity disorder (ADHD), combined type	4/8/2017

Primary Care Provider	Address	Date Identified
No Pcp, Cchmc (513) 578-9715		1/1/0001

E. Record of child's immunizations:

Vaccination	Dates
DTaP Vaccine	01/07/2000, 03/24/2000, 03/09/2001, 03/11/2002, 05/09/2004
Hepatitis A Vaccine 720 Elu	12/23/2011
Hepatitis B Vaccine - HISTORICAL USE ONLY	01/07/2000, 03/09/2001, 03/11/2002
Hepatitis B vaccine 10 mcg (ENGERIX) pediatric	04/05/2014
Hib Vaccine	01/07/2000, 03/24/2000, 03/09/2001
HPV-4 (GARDASIL)	12/17/2010, 03/27/2011, 12/23/2011
Influenza Vaccine 0.5 mL	10/31/2009
Influenza Vaccine Nasal	12/23/2011
Measles/Mumps/Rubella Vaccine	03/09/2001, 05/09/2004
Menactra Vaccine	02/13/2017
Meningococcal Vaccine	12/17/2010
Pneumococcal Vaccine	03/09/2001, 03/11/2002
Polio Vaccine Inactivated	01/07/2000, 03/24/2000, 03/11/2002, 05/09/2004
TDAP Vaccine	12/17/2010
Varicella Vaccine Live	03/09/2001, 12/17/2010

F. Indicate if the child has had any of the following childhood illnesses:*

Illness	Recorded
Chicken Pox	N/A
Hepatitis	N/A
Mumps	N/A
Rubella	N/A
Rubeola	N/A
Whooping Cough	N/A

*Not currently reported. Relevant information may be present within Immunization Records (Section E).

Date Generated: 4/16/2020 Page 2 of 6

- More complete information included as part of the case plan and court report
- Informed discussion during case reviews

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Group reflection

How are you made aware of health needs for the children you serve, and how do you share that information with others?

What challenges do you face in accessing healthcare for youth in foster care?

What challenges do you see when health information is missing?

How do you support young people and their families in accessing healthcare services or getting health information? Where could things be improved?

Conclusions

Children in foster care have increased health risks and require specialized healthcare

Children need advocates who can ensure their healthcare system access and support navigation

Technology can help close gaps between healthcare and child welfare systems, professionals supporting young people

Advocacy to support enhanced access to historic health information between healthcare and child welfare systems is needed – and that can start with you!

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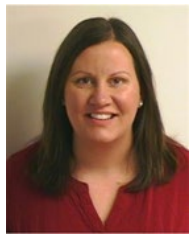
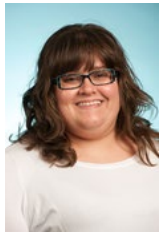
Together we can transform child health and welfare.















CHECK CENTER

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