Working Together

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

2009

New York State
Office of
Children and Family Services
Acknowledgments

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Introduction

Why a Manual on Health Services for Children in Foster Care?

The New York State Office of Children and Family Services (OCFS) is committed to supporting local departments of social services (LDSS, also known as local districts) and voluntary agencies in the provision of adequate, timely health services for children in foster care. This manual is intended to assist and advise foster care and health services staff in focusing attention on this critical issue. As the mental health, developmental, and behavioral needs of children in foster care have increased over the last several years, the provision of health services and coordination of appropriate health care have become more central to achieving their child welfare goals.

All children need health services to identify their condition and needs, diagnose and treat any identified problems, and initiate appropriate follow-up and preventive health care. As a result of health care deprivation and abuse and neglect, children in foster care have a high level of health services needs. Recent research provides the following sobering statistics:

- Approximately 60 percent of children in care have a chronic medical condition, and 25 percent have three or more chronic problems.\(^1\)
- Developmental delays are present in approximately 60 percent of preschoolers in foster care.\(^2\)
- Children in foster care use both inpatient and outpatient mental health services at a rate 15 to 20 times higher than the general pediatric population.\(^3\)
- Between 40 percent and 60 percent of children in foster care have at least one psychiatric disorder.\(^4\)

Children in foster care experience higher rates of physical and emotional problems than those in the general population. This high level of need can be attributed to many factors: exposure to

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2 Ibid.
trauma, the pervasive effects of abuse or neglect, inadequate health care or medical neglect before
entry into care, the inherent stress of out-of-home placement, and movements between settings
that result in interruptions in health services.

The Adoption and Safe Families Act (ASFA) of 1997 provides additional impetus for diligence in
addressing the health needs of children in foster care. For the first time, child welfare agencies are
being held accountable for improving the well-being of children in foster care in addition to
addressing their safety and permanency.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 [Public Law (P.L.) 110-
351] furthers the emphasis on ongoing oversight and coordination of health care for children in foster
care, including their mental and dental health needs.

Healthy People 2010, an important federal initiative, is a set of health objectives for the nation to
achieve during the first decade of the new century. The overarching goals of Healthy People 2010 are:

1. To increase quality and years of healthy life.
2. To eliminate health disparities.

To achieve these public health goals for the nation, programs that provide health services must
incorporate the goals into their work. To do our part in this national public health effort, we have
included references to applicable Healthy People goals for children and adolescents in this manual.

**Audience and Organization of the Manual**

We recognize that there are different health care delivery models for children in foster care across
New York State. How children receive health services varies depending on whether they are placed
in a foster home supervised by the LDSS (direct care) or in a setting operated by a voluntary
authorized agency (indirect care). For the purposes of this manual, we refer to both LDSS and
voluntary agencies as “agencies.”

In addition, health services may be provided directly by the LDSS or agency, or by providers in the
community. These differences are taken into account throughout the manual.

Our intended audience is case managers, case planners, caseworkers, health care coordinators, health
services staff, and any other agency personnel who coordinate or oversee the health needs of children
in foster care. The manual is not designed for caregivers or health care providers. However, parts of
this manual may be used to educate health care providers and caregivers about the health care
guidelines for children in foster care.

Chapters address the initial evaluation of the child’s health, ongoing and preventive health care,
specific health services, medication administration and management, health care coordination, issues
of consent and confidentiality specific to children in foster care, maintenance of health records,
working with health care providers, and ways to support caregivers. At the end of each chapter you
will find helpful resources such as website addresses, program descriptions, and sample tools.
Appendix A contains sample forms and a list of the websites cited in the manual. The sample forms are provided to assist you in organizing the tasks and information described in the manual. Feel free to adapt them as appropriate. Appendix B contains copies of health-related policy documents issued by OCFS. Appendix C contains copies of critical regulations and laws cited in the manual. Appendix D contains the Protocol: Children in Foster Care Who Participate in the Early Intervention Program. Appendix E provides space for you to insert local policies and forms.

Key Concepts

Health Services Guidelines for Children in Foster Care

In 2001, the Office of Children and Family Services developed health services guidelines for children in foster care to provide local districts and voluntary agencies with clear instructions for arranging and coordinating the health care of these children. The guidelines outline the mandated and recommended health services activities needed to support optimal health for children in foster care and comply with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards and state regulations.

➤ EPSDT defines the minimum federal Medicaid required services. The New York State version of EPSDT is known as the Child/Teen Health Plan (C/THP). As children in foster care are now categorically eligible for Medicaid if they are citizens or meet satisfactory immigration status, it is our responsibility to implement this set of core services. In addition, we have included recommendations for best practice to promote optimal health. These are based on research on the health needs of children in foster care. You are encouraged to use your available resources to provide all recommended as well as required services.

Contained within the guidelines are descriptions of the services necessary to address children’s health needs, time frames to accomplish required health activities, qualifications for health care providers, and important concepts around health care coordination, monitoring of health services, and administrative issues. This manual incorporates the guidelines along with other helpful resources and suggestions for managing health services for children in foster care.

Note: The resources listed in this manual are intended to enhance the assessment of health care needs and the delivery of health services to children in foster care, and are not specifically endorsed by the Office of Children and Family Services. Sources for the documents are provided, and the author is responsible for the content. Listings of websites and organizations are included to provide helpful information and tools for foster care and health staff working together with children and families.

The guidelines are drawn from the following sources:

- Federal Medicaid EPSDT (Early and Periodic Screening, Diagnostic and Treatment) standards.
- New York State Medicaid C/THP (Child/Teen Health Plan) standards.
New York State Codes, Rules and Regulations (NYCRR) applicable to services for children in foster care.

New York State OCFS policy documents applicable to children in foster care.

New York State Mental Hygiene Law (MHL).

New York State Public Health Law (PHL).

New York State Social Services Law (SSL).

Child Welfare League of America (CWLA) Standards for Health Care Services for Children in Out of Home Care.

American Academy of Pediatrics (AAP): policy statement, Health Care of Children in Foster Care; and Fostering Health: Health Care for Children in Foster Care in New York State.

Other relevant sources.

Footnote citations to a law or regulation indicate that an activity or component is required and provide the legal or regulatory source for the requirement. Use of the term “should” indicates that an activity is recommended by OCFS as best practice but is not required by law or regulation.

Note: Language with footnote citations may not be quoted verbatim from the particular source. Appendix B contains links to relevant policies, and Appendix C contains links to selected regulations and laws.

Comprehensive Health Evaluation: Five Assessment Domains

The health needs of children fall into five different domains: medical, dental, developmental, mental health, and substance abuse. Although there is overlap across the areas, each has a unique focus with specialty health practitioners and diverse assessment and treatment protocols. All five domains warrant assessment and special consideration. For this reason, information is organized in the manual according to these five domains.

Health Care Coordination

The overarching theme of the manual is “working together” to promote optimal health of children in foster care. This means health care professionals, casework staff, agency staff, caregivers, birth parents, and service providers working collaboratively toward implementing an integrated plan of care. To make this happen effectively, the function of health care coordination is crucial. Simply put, health care coordination is a series of activities that support oversight and responsibility for all aspects of health services for children in foster care. Throughout the manual, “health care coordination activities” are highlighted to indicate ways that staff can coordinate health services and integrate them into permanency planning and case management.
Health care coordination activities may be conducted by a variety of individuals, such as the case manager, foster parent, or agency health services staff. It is recommended that a lead person with a health background be identified to provide or assist with health care coordination. We recognize that local districts and voluntary agencies conduct activities differently and have different staffing patterns. The term “staff” is used to indicate any staff involved with health care coordination.

(See Chapter 4, Health Care Coordination, and Appendix B for the guidance paper, Health Care Coordination for Children in Foster Care: Approaches and Benefits (09-OCFS-INF-01).

Medical Home

When feasible, children should receive all of their health care, including routine preventive, acute illness, and chronic illness, from the same provider prior to foster care placement, while in foster care, and upon discharge, to promote continuity of care. In this model of care, every child has an established, ongoing relationship with a primary health care provider, so that health problems can be identified, treated, and documented early to improve outcomes and reduce the likelihood of disease, disability, and hospitalization.

The concept of the medical home is woven throughout the manual beginning with the initial comprehensive health evaluation.