



Statement of Purpose

The American Academy of Pediatrics (AAP) has long recognized that the health of the individual child is the product of myriad social, environmental, and genetic factors and that adverse conditions in any of these areas undermine the wellness of the child. Children and adolescents in foster care are a singularly disadvantaged and vulnerable population known to be at high risk for persistent and chronic physical, emotional, and developmental conditions because of multiple and cumulative adverse events in their lives.

The Task Force on Health Care for Children in Foster Care is composed of medical, developmental, and mental health professionals dedicated to the health and well-being of children and adolescents in foster care. Its charge from District II, New York State, of the AAP is to define standards of health care delivery and management that promote quality health care and wellness for the complex and medically needy population of children and adolescents in foster care.

Children and Adolescents in Foster Care

Children and adolescents in foster care are a group with special health care needs. They are a uniquely disadvantaged group. Prior to foster care, the vast majority lived with families devastated by substance abuse, mental health disorders, poor education, unemployment, violence, lack of parenting skills, and involvement with the criminal justice system. High rates of premature birth, prenatal drug and alcohol exposure, and postnatal abuse and neglect contribute to the extremely poor health status of children and adolescents entering foster care. In addition, health care prior to foster care placement often is inadequate, meaning that children and adolescents entering foster care have multiple unmet health care needs, far exceeding even those of other children who are poor. Once children

and adolescents are placed in foster care, health care often is sporadic, crisis-oriented, and poorly accessible. The high mobility of the foster care population among placements, ongoing issues of separation and loss, and the complexities of the foster care system exacerbate these problems.

Studies profiling the health status of children and adolescents entering foster care demonstrate high rates of acute and chronic medical problems, developmental delays, educational disorders, and behavioral health conditions. A study done in Baltimore, MD, involving a large cohort of children entering foster care showed that more than 90% had an abnormality in at least one body system. Vision and hearing conditions were common and evidence of suboptimal growth was present in up to 5 times the expected number of children. An Oakland, CA, study showed that less than 20% of a cohort of children in foster care had no medical conditions. More than 20% had growth abnormalities, 30% had neurologic disorders, and 16% had asthma—a prevalence about 3 times the national average for asthma. Another study compared the health care use and expenditures of children in foster care with those of children in the Aid to Families With Dependent Children program in Washington. Twice as many children in foster care used medical equipment or specialist services or were hospitalized. A similar study reviewed the medical records of a large cohort of children entering foster care in San Francisco, CA, and reported medical findings in 60% of the children. A high percentage of younger children had developmental delays and skin conditions, while older children and adolescents had higher rates of vision conditions, dental caries, and positive tuberculin skin test results.

The high incidence of anemia in children in foster care, as well as the high incidence of infectious diseases, has been documented. Infants and children in foster care are at increased risk for a variety of vertically transmitted infectious diseases, such as human

immunodeficiency virus, hepatitis B, hepatitis C, syphilis, and herpes simplex. High-risk behaviors in the adolescent foster care population place them at risk for acquired infectious illnesses, especially sexually transmitted diseases. A recent study indicated that more than 80% of children and adolescents were exposed to domestic or community violence prior to foster care.

Delivery of Health Care Services

There are approximately 550,000 children in foster care annually in the United States. In this diverse country, children and adolescents in foster care are located in a variety of urban, small metropolitan, suburban, and rural settings. Different communities have different resources and models for the delivery of health care services but, in general, there is no systematic approach to the health care of this highly mobile, medically high-risk, complex population. Federal law and regulation stipulate that children whose families are Temporary Assistance for Needy Families (TANF)-eligible at entry to care are automatically eligible for Medicaid. Some states have expanded these eligibility criteria to include all children entering foster care. But there is no cohesive system of health care for this population and no mechanism to identify, recruit, and train health care professionals in foster care health care.

There is little tracking or monitoring of the care that does exist. Current expectations are that caseworkers or foster parents coordinate and plan for the child's health, mental health, and developmental services, but there is limited integration of health care and permanency planning agendas. The dismal health status of children and adolescents in foster care is evidence that this is a woefully inadequate solution. Recent legislation enacted at the federal level (Adoption and Safe Families Act of 1997) shortens the time frame in which foster care caseworkers must pursue termination of parental rights. This, in turn, affects health professionals, who must provide thorough admission assessments, mental health and developmental evaluations, and

comprehensive after-care planning in shorter time frames if children and adolescents are to be appropriately served.

Please note that in this manual we often describe medical providers using the general term physician. In many cases, the functions described may be serviced by qualified pediatricians, family physicians, or nurse practitioners.

Standards for Health Care for Children and Adolescents in Foster Care

In 1988, the Child Welfare League of America (CWLA), in consultation with the AAP, developed *Standards for Health Care Services for Children in Out-of-Home Care*. More recently, the CWLA published guidelines for health care delivery in a managed care environment to children in foster care. Though these general guidelines are important and helpful, the Task Force on Health Care for Children in Foster Care believes that much more specific standards are needed. The AAP has addressed this need through several policy statements (see appendices). Detailed standards (called *practice parameters* in this manual) create venues in which to assess the appropriateness of health care financing and models of health care delivery. While this manual is not specific to any particular model for health care delivery or financing, its standards should be applied rigorously to all such models.

Throughout this manual, it is assumed that high-quality, outcome-focused, accessible, comprehensive, culturally sensitive health care for children and adolescents in foster care is integrated into the child welfare planning for each child and adheres to the following fundamental principles:

- Children in foster care must have a medical home where health care is provided by medical professionals expert in the issues of children and adolescents in foster care. The medical home ideally

- should remain the same despite changes in foster placement or insurance coverage to maximize access and continuity of care.
- Children in foster care need comprehensive health care services, including
 - Preventive health care
 - Care for acute and chronic illnesses
 - A full range of mental health care services
 - Developmental evaluation and services
 - Evaluations for child abuse and neglect
 - After-hours care
 - Emergency care
 - Dental care
 - Children and adolescents in foster care are a discrete population with more intensive service needs than the general pediatric population or even other children who are poor. Current models of health care funding fail to address the more intensive service needs of this population.
 - Indicated preventive educational and mental health care services must be an integral part of the overall care of children and adolescents in foster care. Given the high rates of psychological, developmental and behavioral problems found in this population, efforts to maximize children's physical, emotional, and intellectual development and promote family stability are crucial. Preventive programs may ameliorate the long-term sequelae of chronic childhood stressors. Examples of preventive programs that may benefit children in foster care include peer support groups; support groups for foster parents; infant and child stimulation programs; enhanced education for foster parents and caseworkers; reading promotion; early childhood education; nutrition support through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and the use of foster parent mentors to teach newer foster parents. These services are in addition to the services provided by foster care agencies that are directed

toward birth parents to promote family reunification. Even when evidence indicates the success of an intervention, funding does not necessarily follow. For example, mentoring of birth parents by mental health professionals during visitation with their children has improved reunification outcomes, but funding for this model remains limited.

- Health care management across multiple disciplines (eg, primary care, dental care, medical subspecialty care, mental health care, education, developmental services, social services) is fundamental to ensuring continuity of care for children and adolescents in foster care. Health care management, through advocacy and communication, ensures access and care coordination and is the key to integrating the health and child welfare agendas for these children and adolescents. Successful health and child welfare outcomes depend on an effective integration of services across the social and health care systems. For care management to be translated from a statement of principle to actual practice requires designating and funding responsible staff at the levels of the county child welfare system, voluntary care agencies, and health care sites. It also demands the implementation of a system for communication and follow-up of health care information and the commitment of resources to monitor quality and outcomes. Traditional health care financing does not reimburse the health care management function at the level required for this complex, transient, and needy population.

Cultural Competence

- Cultural competence in health care delivery for children and adolescents in foster care often is overshadowed by the other complex problems of providing appropriate medical, dental, developmental, educational, and mental health care services to this population. Foster care is, in a sense, a microculture, as children and families experience the impact of a child's removal,

are governed by a unique set of regulations and laws, interact with a complex bureaucracy, and deal with large numbers of professionals with sometimes conflicting information and demands. Cultural competence is a critical issue for all health care professionals in general, and it is beyond the scope of this manual to do more than outline its importance for and effect on health care provision for this population. The diversity of racial, ethnic, cultural, and linguistic backgrounds among children and adolescents in foster care and their caregivers presents both challenges and opportunities for health care services, as

- Illness and diseases and their causes are perceived differently across cultures.
- Various belief systems exist related to health, healing, and wellness.
- Help-seeking behaviors and attitudes toward health care professionals are influenced by culture.
- Health care professionals from culturally and linguistically diverse groups are underrepresented in the current service delivery system.
- As health care professionals seek to become more culturally competent, there are actions that can be taken.
 - Place value on diversity.
 - Develop the capacity for cultural self-assessment.
 - Become conscious of the dynamics inherent when cultures interact.
 - Develop institutionalized cultural knowledge.
 - Develop adaptations to service delivery reflecting an understanding of cultural diversity.
- These actions must be supported by acceptance of the following major values and principles:
 - Health care professionals must recognize that racial and ethnic minorities have to be at least bicultural and that this may create a unique set of mental health issues to which they must be able to respond.

- Health care practice is not passive but is driven by culturally preferred choices.
- There are dynamics inherent in cross-cultural interactions that must be acknowledged, adjusted to, and accepted.
- Individuals and families make different health care choices based on cultural forces; these choices must be considered if services are to be effective.

In addition, foster care is a unique culture and has a lasting effect on the lives of children and families, whether they interact with the system briefly or over long periods of time. Changes in health care practice to address issues of cultural competence require appropriate policies and institutional supports in health care delivery systems. Only through broad efforts to bring about systematic changes can enhanced quality of service provision and improved health care access and outcomes for children in foster care from racially, ethnically, and culturally diverse groups be achieved.

Conclusion

The goal of the Task Force on Health Care for Children in Foster Care is to provide high-quality, accessible, comprehensive, culturally sensitive health care for children and adolescents in foster care in such a way that the health plan informs and is effectively woven into the child welfare plan for each and every child. It is the belief of the task force members that tangible improvement in health care services for children and adolescents in foster care will result in healthier children and adolescents, better long-term health outcomes, more stable foster care placements, and higher rates of more timely permanency.

Fostering Health has been designed for use by medical, mental health, and developmental professionals, as well as foster parents, social welfare agencies, legal professionals, health insurance agencies, and policy makers. It is intended to be frequently referred to, adhered to, and improved on. The chapters that follow detail the ideal standards of health care for children and adolescents in foster care.

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