



Fostering Health

**Health Care for
Children and
Adolescents in
Foster Care**

2nd Edition

**Task Force on Health Care for Children
in Foster Care**

**American Academy of Pediatrics
District II, New York State**



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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Executive Summary

Children and adolescents in foster care have a higher prevalence of physical, developmental, dental, and behavioral health conditions than any other group of children. Typically these health conditions are chronic, under-identified, and undertreated and have an ongoing impact on all aspects of their lives, even long after these children and adolescents have left the foster care system. In general, children and adolescents in foster care

- Are all ages and ethnic groups.
- Are the children of the emotionally and financially impoverished.
- May have been homeless, exposed to domestic violence, malnourished, or had multiple caregivers prior to foster care.
- May have had prenatal drug and alcohol exposure and/or suffered from abuse and neglect prior to foster care.
- May have a parent who is mentally ill or addicted to drugs and alcohol.
- Live in the uncertain, unpredictable world of foster care, separated from their families of origin but remaining, however tenuously, connected and longing to return to them.
- Have caseworkers that struggle with trying to meet the conflicting mandates of the system addressing permanency planning while trying to ensure their health and safety.
- Live in a world of impermanence, fragmentation, and instability, while in desperate need of permanence, cohesion, and stability.
- Live in foster homes, group homes, residential treatment facilities, and sometimes even juvenile justice facilities. Their world is further complicated by changes in placement, visitation, and contact with siblings and their lack of control over their lives.

Current health care models have been inadequate in addressing the complex health care agenda presented by children and adolescents in foster care. In the spring of 1997, the American Academy of

Pediatrics Committee on Early Childhood, Adoption, and Dependent Care convened a special multidisciplinary team, the Task Force on Health Care for Children in Foster Care, to address the need for health care practice standards for children and adolescents in foster care. The task force was charged to “define the components of service and care coordination that promote quality health care for these children.” This resource manual is intended to fulfill that charge.

Fostering Health has been designed for use by medical, mental health, and developmental health care professionals, as well as foster parents, social welfare agencies, members of the legal community, health insurance agencies, and policy makers. It is intended to be frequently referred to, adhered to, and improved on.

Standards of health care for children and adolescents in foster care are detailed in 10 chapters. Three chapters focus on practice parameters for primary health care, developmental and mental health care, and child abuse and neglect. These practice parameters identify events and related encounters, their purposes, the time frames for their accomplishment, the types of professionals involved, and the procedures to be performed. The types of primary care events and encounters detailed in Chapter 2 include health information gathering at time of removal, initial medical screen, ongoing health information gathering, comprehensive health assessment, follow-up assessment, periodic preventive health care, discharge, and other encounters. Practice parameters for developmental and mental health care—comprehensive assessment, treatment services, periodic assessments and review of the treatment plan, and developmental and mental health care coordination—are described in Chapter 3. Chapter 4, “Practice Parameters for Child Abuse and Neglect,” provides protocols for child abuse and neglect screening, child abuse and neglect evaluation, triage and evaluation for child sexual abuse, and steps to take if child abuse or neglect is suspected.

Chapter 5, “Health Care Management,” discusses a new system of coordination of services that must be in place to ensure that children and adolescents in foster care receive high-quality, comprehensive, and coordinated health care. Chapter 6, “Medical Consents for Children and Adolescents in Foster Care,” delineates general principles concerning when and by whom medical consents should be obtained. Confidentiality issues are summarized in Chapter 7.

Each child or adolescent in foster care requires a medical home. The health care professionals who assume this responsibility must have experience or training in all aspects of the foster care system; understand the impact of foster care on children, adolescents, and their families; and be willing to work collaboratively and closely with child welfare agencies. Chapter 8, “Qualifications of Health Care Professionals,” addresses essential characteristics of professionals who can be considered well qualified to provide services to children and adolescents in foster care.

Quality assessment and improvement are designed to achieve the highest level of patient care delivery and outcomes with effective and efficient use of available resources. The practice parameters set forth in this manual can serve as measures of quality for this population as universal indicators for children are being developed (Chapter 9). Resource issues are discussed in Chapter 10, “Health Care Financing for Children and Adolescents in Foster Care.”

The members of the Task Force on Health Care for Children in Foster Care hope that this manual will result in the integration of the health care plan with child welfare’s permanency plan for each child or adolescent in foster care. Adoption of these standards can

- Provide health care and child welfare professionals with a framework on which to build health care services for children and adolescents in foster care in a way that fully supports the mandate for child welfare services to not only protect and ensure the safety of

children and adolescents, but to do all they can to ensure their future well-being.

- Ensure that identified or unidentified and unmet health care needs do not present significant barriers to effective permanency planning for children and adolescents in foster care, whether the goal is reunification, adoption, or independent living.
- Support an understanding by medical, mental health, and child welfare professionals that children in foster care are a population with special needs requiring access to high-quality health care services that are well coordinated, continuous, comprehensive, and culturally informed and provided by health care professionals who are familiar with the mandates, obligations, and intricacies of the foster care system.
- Place an obligation on health care professionals to face the critical responsibilities of bringing together the fragmented health care histories of these children and adolescents and offer an after-care health plan that addresses continuing health care needs and issues.



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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Practice Parameters for Primary Health Care

Given the prenatal and environmental risk factors with which children and adolescents enter the foster care system and the illness profiles described by the studies listed in the bibliography in Chapter 1, it is imperative that primary care physicians who care for children and adolescents in foster care view them as children with special health care needs. Primary care physicians must maintain a high index of suspicion for a multitude of physical, developmental, educational, dental, and behavioral conditions. In addition, because of the unique environment in which children and adolescents in foster care live and the bureaucratic and regulatory structure that surrounds them, primary care physicians must approach the task of providing services to these children and adolescents with a very special perspective. The following describes general principles of practice that must govern the delivery of health care to children and adolescents in foster care and the characteristics of the foster care medical home.

Principles of Practice

Interaction With Child Welfare Personnel

Health care professionals must be prepared to work closely with the social service agencies responsible for children and adolescents in foster care. Information must flow freely between social service and medical staff to ensure optimal care (*see* Chapter 5).

Communication With Birth and Foster Parents

In addition to interacting with social service staff, health care professionals must communicate effectively with foster parents and, when

available, birth parents. If the ultimate goal for children is family reunification, health care professionals must make every effort to engage birth parents in the health care of the children. Child welfare and health care management staff (*see* Chapter 5) can facilitate the involvement of birth parents. Information must be shared in a culturally sensitive and easily understood manner.

Health Education and Wellness Promotion

Health education is essential to providing effective health care to this population. Efforts to provide health education should be directed toward the social service staff, consulting staff, foster parents, birth parents, and children and adolescents. Adolescents aging out of foster care should have extensive health education prior to final discharge.

Intensity of Encounters

Given the multitude of health, developmental, and emotional issues that children and adolescents in foster care have and the number of individuals with whom information must be shared, it is evident that health care professionals must be prepared to devote significantly more time to their encounters with children and adolescents in foster care.

Medical History

Social service and medical staff must make every effort to obtain complete medical histories on children and adolescents as they enter foster care. However, health care professionals must be prepared to provide services to children and adolescents with little or no medical information available, especially early in placement. Ideally, while in foster care, each child will have a centralized medical record and/or file at the foster care agency that is updated on a regular basis.

Child Abuse and Neglect Issues

It is never more important for the health care professional to act as a child advocate than when caring for children and adolescents in foster care. Health care professionals must be able to adequately assess

children for child abuse and neglect issues at entry to foster care. In addition, they must always be alert to signs of suboptimal caregiving on the part of foster parents. Growth parameters must be diligently followed, as growth failure often is the first sign of mismatch between children and foster homes. Observing interactions between foster parents and children in the office setting allows health care professionals to assess the quality of the parent-child relationship and whether there is a mismatch. And of course, health care professionals always must be alert to signs or symptoms of frank neglect or abuse. Primary care physicians must communicate any concerns about the foster care placement or visitation as soon as possible to the appropriate child welfare staff.

Special Training

In addition to maintaining competency in all areas of general pediatrics, primary care physicians who work with children in foster care must be

- Well-versed in the topics of abuse and neglect
- Well-versed in infant, child, and adolescent development
- Cognizant of the impact of foster care on families and children
- Comfortable dealing with significant behavioral and psychiatric disorders, in cooperation with mental health professionals
- Familiar with the child welfare system and its policies and procedures and able to navigate through its bureaucratic structure, working closely with health care managers

Coordination of Multiple Health Care Needs

Given the complexity of the physical, emotional, and developmental health conditions of children and adolescents in foster care, a multidisciplinary treatment plan is often indicated. Because many specialists may be involved in the care of a particular child, primary care physicians must be prepared to coordinate myriad services and ensure that information flows easily between specialists, social services, and primary care physicians.

The Medical Home Model for Children and Adolescents in Foster Care

Children and adolescents in foster care have experienced episodic, fragmented, and inadequate health care prior to foster care and, once in foster care, it is not unusual for them to experience multiple changes in foster home placement, leading to further disruption in health services. It is imperative that this population has consistency in its health care. According to the American Academy of Pediatrics (AAP) and the federal Maternal and Child Health Bureau, a medical home for any child has certain characteristics. It is a medical practice that is accessible and family-centered and provides high-quality care that is comprehensive, coordinated, compassionate, and continuous over time. In addition to these qualities, a foster care medical home should be staffed by pediatric health care professionals who understand the effect of foster care on children and families, are familiar with the regulations and mandates of child welfare, and have expertise in child abuse and neglect. In addition, physicians in foster care health care must be willing to work in collaborative cooperative partnership with child welfare personnel, foster and birth parents, and multiple other professionals on behalf of these children and families.

Children and adolescents in foster care should receive all of their health care services (ie, routine preventive, acute illness, chronic illness) from a single health care professional who will get to know them, with whom they can bond, and in whom they can confide. They need to be able to point to a health care professional and enthusiastically proclaim, “That’s my doctor!”

Parameters for Primary Health Care

This section details the components of primary health care encounters that are specific to children and adolescents in foster care. For each encounter, the purpose, time frame for its accomplishment, type of health care professional involved, and procedures to be performed

are described. These details are provided for the following types of encounters or events:

- Health Information Gathering at Time of Removal
- Initial Medical Screen
- Ongoing Health Information Gathering
- Comprehensive Health Assessment
- Follow-up Assessment
- Periodic Preventive Health Care
- Discharge Encounter
- Other Encounters Unique to Foster Care
 - Intra-Agency Transfer
 - Return to Care Within 90 Days
 - Return to Care After 90 Days
 - Visitation With Birth Parents

Health Information Gathering at Time of Removal

Purpose

1. To identify medical, developmental, and mental health conditions that require prompt medical attention*
2. To identify chronic physical, developmental, and mental health conditions that will require ongoing therapy
3. To identify health conditions that will affect the selection of a foster home

**Refer to a pediatric ambulatory service or pediatric emergency department for conditions warranting immediate attention.*

Time Frame

At the time of removal.

Performed By

Child welfare staff (with medical consultation as indicated).

Components

1. Information to be obtained
 - Site of ongoing health care (eg, clinic, physician office) prior to foster care placement—this is crucial because most of the following information will be obtained from these sources
 - Chronic medical, developmental, or mental health conditions (eg, asthma, sickle cell disease, seizure disorder, diabetes, autism, depression)
 - Hospitalizations, including psychiatric and residential treatment (when/where/why)
 - Surgery (when/where/why)
 - Medication (names/indications/doses)
 - Allergies (eg, food, medication, insect stings)
 - Hospital of birth
2. Items to accompany child
 - Eyeglasses
 - Medication
 - Medical equipment (eg, nebulizer, spacer, orthotics, hearing aids)
 - Immunization record
3. Information on newborns discharged from nursery into foster care
 - Discharge summary
 - Follow-up appointments
 - State newborn screening form
 - Immunization record
 - Results of newborn hearing screening

Initial Medical Screen

Purpose

1. To identify health conditions that require prompt medical attention such as acute illnesses, chronic diseases requiring therapy (eg, asthma, diabetes, seizure disorder), signs of abuse or neglect, signs of infection or communicable diseases (eg, varicella, lice,

- tinea), hygiene or nutritional problems, pregnancy, and significant developmental or mental health disturbances
2. To identify health conditions that should be considered in making placement decisions

Time Frame

Within 24 hours of removal.

Performed By

Child welfare staff or designated primary care physician. (Ideally, this will be the child's medical home while in foster care.)

Components

1. Review of available medical, developmental, and mental health history
2. Review of systems (standard medical review)
3. Symptom-targeted examination to include
 - Vital signs (with blood pressure measurement if 3 years or older)
 - Height and weight (and head circumference, if younger than 3 years) with percentiles, and calculate body mass index
 - If indicated or available, physical examination by physician or pediatric nurse practitioner (Ideally, this is included at this visit.)
 - External body inspection (unclothed) for signs of acute illness, signs of abuse (unusual bruises, welts, cuts, burns, trauma), and rash suggestive of infestation or contagious illness; range-of-motion examination of all joints by health staff
 - External genitalia inspection for signs of trauma, discharge, or obvious abnormality by health staff
 - Assessment of chronic conditions (eg, respiratory status if known to have asthma)
4. Developmental and mental health screen (using standard screening tool) for
 - Significant developmental delay

- Major depression
 - Suicidal thoughts
 - Violent behavior
5. Actions that may be required after medical screen
Referral to primary care physician, pediatric ambulatory service, or pediatric emergency department for conditions warranting immediate attention or evidence of abuse warranting further evaluation, documentation, and treatment. For history and/or physical findings suspicious for sexual abuse, referral is recommended to a center with staff that specializes in evaluation, documentation, and treatment of sexual abuse (*see* Chapter 4).

Ongoing Health Information Gathering

Purpose

1. To identify past and ongoing health, behavioral, and developmental conditions
2. To obtain necessary information not documented at time of removal
3. To supplement information documented at the time of removal
4. To begin the process of developing a comprehensive profile of the child or adolescent and birth parents

Time Frame

Begin as soon as possible after placement. This is an ongoing process that begins at removal and continues while the child or adolescent is in care. As much of the past medical history as possible should have been gathered prior to the comprehensive health assessment for review by health care professionals.

Performed By

Health care manager.

Components

1. Complete medical history
 - Chronic medical conditions (eg, asthma, sickle cell disease, seizure disorder)

- Hospitalizations (when/where/why)
 - Surgery (when/where/why)
 - Medication (names/indications/doses)
 - Allergies (eg, food, medication, insect stings)
 - Immunization record
2. Complete perinatal history
For all children from birth to 6 years of age and older children as appropriate.
- Hospital of birth
 - Mother's age/gravidity/parity
 - Prenatal care
 - Illnesses or infections during pregnancy
 - Medications during pregnancy
 - Drugs, alcohol, or tobacco use during pregnancy
 - Problems with labor or delivery; type of delivery
 - Gestational age
 - Weight, length, and head circumference at birth
 - Apgar scores
 - Urine toxicology results; other laboratory tests including syphilis serology and hepatitis screen
 - Problems in nursery or neonatal course (eg, respiratory problems, jaundice, feeding difficulties, cardiac problems, neurologic problems)
 - State newborn screen results; hearing screen results
3. Family medical history
A complete family medical history should be obtained with particular attention to asthma, tuberculosis, hepatitis, sexually transmitted diseases, human immunodeficiency virus (HIV) infection, drug and alcohol use, genetic disorders, developmental and learning issues, and psychiatric illness.
4. Developmental history of child
For all children from birth to 6 years of age and older children as appropriate.

5. Psychosocial history[†]

- Reasons for placement in foster care
- Type of placement
- History of previous placements and preventive services
- Household composition (ie, history of child's living arrangements over time)
- Family interactions
- Status of siblings
- History of domestic violence
- History of child abuse and/or sexual abuse
- History of drug or alcohol abuse by family members or caregivers
- Occupation and education of parent(s)
- Child care arrangements
- Prior housing and living arrangements (eg, homelessness, frequent moves)

[†]*Psychosocial report prepared by child welfare staff, if complete, could serve as the source of this information.*

6. Behavioral and mental health history of child or adolescent

To include any mental health diagnoses, the use of psychotropic medications, inpatient and outpatient therapy, and history of substance abuse.[‡]

[‡]*Informed consent by the child's legal guardian is required for the administration of psychotropic medications to children in foster care (see chapters 6 and 7).*

7. Nutritional history

- For infants: breastfeeding or formula feeding, solids and age of introduction, use of vitamins, fluoride, and iron
- Food allergies, food intolerance, and food preferences
- Dietary restrictions of any kind

8. School history

- Current child care, preschool, or school placement
- Early intervention programs, preschool special education, or special education programs (The results of testing that has been performed should be requested.)

- Past or current need for special services (eg, special education, occupational therapy, physical therapy, speech therapy)
- School performance and behavior

9. Request for records

Medical records from the following should be requested as soon as possible after a child or adolescent enters foster care:

- Past and current primary care physicians
- Specialty care professionals
- Medical centers where child was hospitalized, including center of birth
- Local immunization registry
- Previous foster care agencies
- Early intervention programs, preschool special education programs, and special education programs (The results of testing and individualized educational plans should be requested.)
- Mental health professionals
- Schools (They are important resources for immunization records.)
- Dental professionals

10. Consent from birth parents

The initial contact with birth parents should be used as an opportunity to obtain consent for routine and emergency medical care, as well as for the release of past medical records, as per state regulations. Each state has regulations addressing the timeliness of consents and who may sign consents (*see* Chapter 6).

11. Foster parents update

All significant medical information should be shared with the foster parents as soon as possible after it becomes available to the caseworker, health care professional, and/or child welfare staff.

An appointment should be scheduled for birth parents or other prior caregivers to meet with health care professionals and their staff as soon as possible after placement in foster care. A complete history then can be obtained by health professionals directly. This encounter also serves to involve birth parents in the treatment plan.

Comprehensive Health Assessment

Purpose

1. To review all available data and medical history about the child or adolescent
2. To identify medical conditions
3. To identify developmental and mental health conditions requiring immediate attention
4. To develop an individualized treatment plan

Time Frame

Within 30 days of foster care placement (preferably as soon as possible following placement).

Performed By

Pediatric nurse practitioner or physician of child care agency or primary care physician. The health care professional who performs the comprehensive health assessment ideally should continue to follow the child or adolescent throughout his or her stay in foster care, and possibly beyond (*see* “Standards for Health Care for Children and Adolescents in Foster Care,” Chapter 1, page 4).

Attended By

Children or adolescents, foster parents, health care manager, case-workers, and, when possible, birth parents.

Components

1. Elicit or review complete medical, behavioral, developmental, and social history when possible.
2. Review of systems (ie, standard medical review).
3. Complete unclothed physical examination, including genital examination.
4. Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment with appropriate reporting. The use of figure drawings is helpful; photographs may be taken. Any history or physical findings suggestive of sexual abuse must be fully evaluated, documented, and reported.

Primary care physicians with limited experience in this area should refer to a specialty center (*see* Chapter 4).

5. Family planning and sexual safety counseling services and appropriate examination should be provided for sexually active females as soon as possible. This should be performed by the primary care physician or a specialist in adolescent medicine.
6. Developmental screen with full evaluation to follow.[§]
7. Mental health screen with full evaluation to follow.[§]

[§]*See Chapter 3.*

8. Adolescent survey (ie, discussion with adolescent) to include at a minimum
 - Family relationships (foster and birth)
 - Adjustment to foster care
 - Peer relationships
 - Alcohol, drug, or tobacco use
 - Sexual orientation
 - Sexual activity
 - Prevention of sexually transmitted diseases (STDs) and birth control
 - Nutrition
 - Physical activity (ie, exercise)
 - School performance
 - Hobbies
 - Educational or career plans

The use of a written questionnaire should be considered to help gather this information (*see* “Bibliography”). Counseling about these issues should be initiated with follow-up appointments, with further counseling scheduled as needed.

9. Immunization review

Every effort should be made to locate the immunization record by the comprehensive health assessment. If this is not possible, the record should be located within 30 days so that an immunization update can be done at the follow-up visit. In the absence of an

immunization record at 60 days post-entry, immunizations should be commenced using the catch-up schedule from the AAP and Centers for Disease Control and Prevention (CDC).

10. Dental and oral evaluation

Examination of the oral cavity by the primary care physician is an important part of the comprehensive health assessment, as well as of each periodic preventive health care visit. Anticipatory guidance for oral health appropriate for the child's age also should be a part of these health care encounters. The presence of any risk factors or abnormal findings requires referral to a pediatric oral health care professional or general practice dentist, regardless of the child's age.

- The AAP recommends that children be referred for their first dental evaluation by 2 years of age, with earlier referrals as indicated.
- The American Academy of Pediatric Dentistry (AAPD) recommends that initial and periodic oral health examinations by trained pediatric oral health care professionals begin at 1 year of age.

11. Hearing and vision screening with referral

- Subjective from birth to 3 years of age.
- Objective for 3 years and older.

12. Human immunodeficiency virus risk assessment

Health care professionals should assess patients' capacity to consent for HIV testing based on their ages, developmental ages, and abilities to comprehend what testing means and comply with follow-up. Health care professionals should assess each patient for risk of HIV infection based on history and newborn screening where available.||

||Assessment of capacity to consent for HIV testing and of risk for HIV infection must be in accordance with guidelines set forth by each state for children and adolescents in foster care. Newborn HIV screening results are available in some states for all children and adolescents born in that state.

13. Laboratory studies (if not well documented in medical records or records not available)

- Hemoglobin or complete blood count (CBC) (all children younger than 6 years and adolescent females)
- Lead level for children 6 months to 6 years of age, or older child if indicated
- Hemoglobin electrophoresis for children at risk for hemoglobinopathies
- Purified protein derivative tuberculin (PPD) (3 months and older)—must be read by health care personnel within 48 to 72 hours
- Hepatitis B surface antigen (HBsAg) strongly recommended for all ages
- Rapid plasma reagin (RPR) test strongly recommended for all ages
- Urinalysis—dipstick (children older than 2 years or if indicated)
- Human immunodeficiency virus testing if positive risk assessment and if appropriate consent has been obtained[§]
- Hepatitis C antibody screen for those at risk strongly recommended

[§]*Procedure for obtaining consent for HIV testing and referral for testing as per state regulations.*

14. Universal precautions

Discuss with foster parents the use of universal precautions.

15. Anticipatory guidance[#]

Education and counseling is a critical component of each preventive health care encounter, especially for children and adolescents in foster care. The primary care physician should conduct a private interview with the older child and adolescent at this visit. General areas to be covered include

- Temperament
- Developmentally appropriate play or activities, including reading

- Physical activity and exercise
- Good parenting practices
- Discipline
- Nutrition
- Dental and oral health
- Injury prevention
- Child care arrangements

Topics for discussion with the older child and adolescent include

- Normal development
- Good health habits
- Dental and oral health
- Physical activity and exercise
- Discipline
- Sexually transmitted disease and pregnancy prevention
- Human immunodeficiency virus prevention
- Sexuality issues, including gender identity and sexual orientation
- Substance abuse issues (eg, drugs, alcohol, tobacco)
- Academic activities, including the importance of reading
- Future plans

Topics specific to foster care that should be discussed with the foster parent and older child and adolescent include

- General adjustment to new home
- Dealing with different expectations in different families
- Grief and loss issues
- Contact with birth parents, including adjustment issues around visits
- Behavioral problems that have surfaced (eg, adjustment reactions, oppositional behavior, depression, anger, attentional or impulse control problems)
- Sleep problems
- Appetite or unusual eating habits
- Enuresis or encopresis

- School placement, changes in school settings, peer relationships
- Behavioral or academic school problems
- Interaction with other children in home

#Some of this discussion may have to be delayed until the follow-up visit, depending on how long the child or adolescent has been in the home and how well the foster parent knows the child or adolescent.

16. Referrals

For specialty or ancillary services as needed.

A summary of findings and recommendations, including an individual treatment plan, should be prepared for each child and adolescent; shared with the child or adolescent, foster parents, birth parents, social worker, and health care manager; and become part of the health record and child welfare case plan.

Follow-up Assessment

Purpose

1. To identify medical, mental health, developmental, and educational problems that have surfaced since the child or adolescent has entered foster care
2. To assess “goodness of fit” between the child or adolescent and foster parents
3. To update immunizations
4. To provide health education for issues relevant to the child’s condition or issues of concern to foster parents
5. To review findings from developmental and mental health assessments (if completed)
6. To update, refine, and reinforce treatment plan (This visit provides an opportunity for the primary care physician to meet with the social worker and birth parents, when appropriate, to review findings and promote their integration into the child welfare permanency plan.)

Time Frame

30 days after the comprehensive health assessment.

Performed By

Ideally, the health care professionals in the foster care medical home, who will follow children or adolescents throughout their stay in foster care. Alternatively, pediatric nurse practitioners or physicians of child care agencies may conduct this visit.

Attended By

Children or adolescents, foster parents, caseworkers, and, when possible and appropriate, birth parents.

Components

1. Physical examinations
 - May not be necessary at this encounter unless preventive periodic health care is due at this time or an acute problem is present.
 - A weight check is imperative at this visit for children younger than 3 years. Inadequate weight gain often is the first sign of foster parent–child mismatch. Consider a weight check for all other children.
 - Conduct a brief skin inspection for signs of abuse or maltreatment, especially for children younger than 10 years or any developmentally delayed child.
2. Observation of parent–child interaction

Close observation of the goodness of fit between foster parents and children is an important part of this encounter.
3. Discussion with foster parents about
 - Medical issues that have arisen since entry to home
 - Contact with birth parents, including adjustment issues around visits
 - Grief and loss issues
 - Behavioral problems that have surfaced

- General adjustment (eg, to home, school, or child care) and issues that have surfaced (eg, adjustment reactions, oppositional behavior, depression, anger, attentional or impulse control problems)
 - Sleep problems
 - Appetite issues, unusual eating habits, or food-hoarding behaviors
 - Enuresis or encopresis
 - School placement
 - Behavioral or academic school problems
 - Relationships with adults and other children in the foster home
4. Discussion with the child or adolescent
The physician should conduct a private interview with the older child or adolescent at this visit.
 - The child's overall contentment in the new home and feelings toward the foster parents.
 - Adjustment to visitation and feelings around birth parents.
 5. Immunization update
Begin an accelerated schedule at this visit as per AAP and CDC guidelines if the record has not been located by this time, and report all vaccines to local immunization registry (if applicable).
 6. Health education
Include issues relevant to any problems identified or issues of concern to the child or adolescent, foster parents, birth parents, and/or social workers.
 7. Review of specialty referrals
Ascertain if scheduled appointments were kept, verify that reports were received, and make certain that foster parents are aware of upcoming appointments.
 8. Review of treatment plan
Review the treatment plan with the older child or adolescent, foster parents, birth parents, and/or social workers.

9. Next appointment**

Establish the time for the next appointment with the primary care physician in the medical home, as needed (see the following section, “Periodic Preventive Health Care”).

***If comprehensive developmental and mental health evaluations have not occurred or the information is not yet available, another follow-up appointment should be scheduled to review the findings and treatment plan.*

A summary of findings and recommendations, including an individual treatment plan, should be prepared for each child and adolescent; shared with the child or adolescent, foster parents, birth parents, social worker, and health care manager; and become part of the health record and child welfare case plan.

Periodic Preventive Health Care*Purpose*

1. To promote overall wellness by fostering healthy growth and development
2. To identify significant medical, behavioral, emotional, developmental, and school problems through periodic history, physical examination, and screenings
3. To regularly assess for success of foster care placement
4. To regularly monitor for signs or symptoms of abuse or neglect
5. To provide age-appropriate anticipatory guidance on a regular basis to children and adolescents in foster care and foster and birth parents

Time Frame

In general, more frequent preventive pediatric visits are recommended for the child or adolescent in foster care because of the multiple environmental and social issues that can adversely impact their health and development. Follow the most recent AAP “Recommendations for Preventive Pediatric Health Care” schedule with the following modifications:

- Monthly visits up to 6 months of age.
- Semiannual visits beyond 2 years of age through adolescence.
- Given the high incidence of complex medical, developmental, and mental health conditions in this population, primary care physicians will need to schedule additional visits on a case-by-case basis.

Performed By

Periodic pediatric preventive health care visits should be conducted by the foster care medical home professional to ensure the continuity of care deemed essential for this population. Alternatively, pediatric nurse practitioners or physicians of child care agencies may conduct these visits.

Attended By

Children or adolescents, foster parents, caseworkers, and, when possible and appropriate, birth parents.

Components

Follow the most recent AAP “Recommendations for Preventive Pediatric Health Care” schedule, with the following modifications:

1. History and physical examination with special attention to
 - Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment, with appropriate reporting.
 - Close monitoring of growth parameters is critical for this population. Poor weight gain often is the first sign of a suboptimal placement.
 - Assessment of capacity to consent for HIV testing and assessment of any risk for HIV infection at every periodic preventive health care visit, as per individual state regulations.
 - Observation of parent-child interaction for goodness of fit.
2. Sensory screening
 - Vision and hearing screening appropriate for the child’s age.
 - Refer for specialized audiology evaluation if speech and language delay is suspected or detected.

3. Procedures

- Immunizations

The *Recommended Childhood and Adolescent Immunization Schedule*, which is updated yearly by the Advisory Committee on Immunization Practices of the CDC, the AAP, and the American Academy of Family Physicians (AAFP), should be followed (*see* pages 44–45). An accelerated schedule should be followed in cases of incomplete or missing immunization records. Given the multiple risk factors that children and adolescents in foster care often face, the following are recommended:

- Hepatitis B vaccine for all infants, children, and adolescents.
- For newborns, follow the hepatitis B immunization schedule for mothers who test positive for HBsAg if perinatal history is unknown.
- Pneumococcal conjugate vaccine is recommended for all children up to 6 years of age.
- Meningococcal vaccine is recommended for college-bound adolescents.
- Influenza vaccine for all children 6 months to 2 years of age unless contraindicated or HIV status unknown

- Annual screenings

- Annual screening with a blood lead test for children 6 months to 6 years of age (for children with documented risk for high-dose lead exposure, screening with a blood lead test should be done according to the schedule set forth in the *Physician's Handbook on Childhood Lead Poisoning Prevention* [*see* “Bibliography”]).
- Consider annual hemoglobin or CBC up to and including 6 years of age.
- Consider annual hemoglobin or CBC for post-menarchal females.

4. Procedures for patients at risk

- Purified protein derivative tuberculin annually for children in congregate care

- Purified protein derivative tuberculin every 2 to 3 years for all other children and adolescents per AAP guidelines for populations at high risk

5. Anticipatory guidance

Education and counseling is a critical component of each preventive health care encounter with children and adolescents in foster care. The practitioner should conduct a private interview with the older child or adolescent at each preventive health visit. General areas to be discussed with foster parents include

- Temperament
- Developmentally appropriate play or activities, including reading
- Visitation with birth parents
- Ongoing support for the child and adolescent through process of foster care
- Physical activity and exercise
- Good parenting practices
- Discipline
- Nutrition
- Dental and oral health
- Injury prevention
- Child care arrangements

Topics for discussion with the older child or adolescent include

- Normal development
- Relationships with foster and birth parents
- Continued adjustment to foster care
- Good health habits
- Dental and oral health
- Physical activity and exercise
- Discipline
- Sexually transmitted disease and pregnancy prevention
- Human immunodeficiency virus prevention
- Drug, tobacco, and alcohol use

- Sexuality issues, including gender identity and sexual orientation
 - Academic activities, including the importance of reading
 - Future plans
6. Initial dental referral
- The AAP recommends that all children be referred for their first dental evaluation by 2 years of age. Earlier dental evaluations may be appropriate for some children. Subsequent examinations should be scheduled as prescribed by the dentist.
 - The AAPD recommends that initial and periodic oral health examinations by trained pediatric oral health care professionals begin by the first birthday. Oral screening by primary care physicians should occur prior to this age, with referral to dentists as deemed medically necessary.

Discharge Encounter

Purpose

1. To review medical, mental health, social, and developmental conditions identified during the child's stay in foster care
2. To identify any ongoing conditions that will require intervention after discharge
3. To ensure appropriate follow-up care after discharge
4. To convey a summary of the child's health history to appropriate caregivers and new primary care physicians

Time Frame

On final discharge from current foster care placement (this includes discharge because of reunification, adoption, independent living, or transfer to a different agency).

Performed By

Primary care physicians from the medical home or physicians of child care agency.

Attended By

Children or adolescents, foster or adopting parents/caregivers, case-workers, and, when appropriate, birth parents.

Components

1. Review the medical record.
2. Obtain interval health history from current foster parents.
3. Complete unclothed physical examination.^{††}

††State regulations may not require a comprehensive physical examination at the time of discharge, as long as the AAP “Recommendations for Preventive Pediatric Health Care” schedule has been followed. In the case of discharge to adoption, a comprehensive physical examination usually is required if one has not been performed within the preceding 6 months.

4. Final immunization update with reporting to local immunization registry (if applicable).
5. Conference with receiving caregiver (eg, adoptive parents, birth parents or relatives, new foster parents, agency representatives) or adolescent (ie, independent living). A detailed, written, comprehensive health history should be provided, including conditions identified while in foster care, all medications and vaccines, and the need for any ongoing interventions.

Exception: HIV-related information must not be disclosed to the birth parents/guardians without written permission for children or adolescents with capacity to consent (see Chapter 6).

6. Identify the new primary care physician, if necessary, and schedule the appointment with the new primary care physician.
7. A copy of the discharge health summary and immunization record should be given to the receiving parents or guardians or the adolescent who will be living independently. A copy should be forwarded to the receiving agency in the case of transfer between agencies. A copy also should be sent to the new primary care physician.

8. Follow-up appointments for primary, specialty, or ancillary care, including Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Early Intervention Services, and/or Supplemental Security Income (SSI), should be arranged.
9. Facilitate and coordinate after-care services through the health care manager.
10. After-care health care management should continue for 3 to 6 months to ensure that follow-up appointments are kept. A public or community health nurse referral may be advantageous to ensure that recommended care and health education occur.

Other Encounters Unique to Foster Care

Intra-Agency Transfer

Purpose

1. To inform new foster parents about children's medical histories and any chronic or acute medical, developmental, or mental health conditions requiring treatment.
2. To transfer medical information to new primary care physicians in those cases in which transfer to a new home or facility involves a change in health care professional. Ideally, with an intra-agency transfer, the medical home is unchanged.
3. To screen for any signs of abuse or neglect on transfer to a new home or facility.

Time Frame

At the time of transfer to a new foster home or facility within the same agency.

Performed By

Nursing staff of child care agency or primary care physician's designated nursing staff.

Attended By

Children or adolescents, previous foster parents, new foster parents, facility staff, and caseworkers.

Components

1. Unclothed body inspection for suspicious bruises, welts, scratches, cuts, burns, or swelling with careful documentation and reporting, if necessary (*see* Chapter 4).
2. Referral to the primary care physician for any illnesses or injuries requiring treatment.
3. Conference with new foster parents to inform them of complete medical history of the child or adolescent and any chronic or acute medical, developmental, mental health, or dental conditions requiring treatment.
4. Copy of medical summary and immunization record forwarded to new primary care physician if the transfer involves a change in physician.
5. Transfer of medications, eyeglasses, and medical equipment to new foster parents with instructions on dispensing, storing, side effects of medication, and use of equipment; consider public or community health nurse referral for education.
6. Transfer of immunization record and health summary to new foster parents, as well as any documents needed to access health care.
7. Conference with new foster parents to include information on any upcoming and/or ongoing appointments with subspecialists or ancillary health care professionals.
8. Schedule next appointment with primary care physician.

Return to Care Within 90 Days

Purpose

1. To document any medical or mental health conditions that occurred while the child or adolescent was out of care

2. To screen for any signs of abuse or neglect inflicted while the child or adolescent was out of care

Time Frame

Within 24 hours of returning to foster care following a trial or final discharge from foster care or child's absence without leave from foster care.

Performed By

Nursing staff of child care agency or primary care physician's designated nursing staff.

Attended By

Children or adolescents, foster parents, and, when possible and appropriate, birth parents.

Components

1. Unclothed body inspection for suspicious bruises, welts, scratches, cuts, burns, or swelling with careful documentation and reporting, if necessary (*see* Chapter 4).
2. Referral to the primary care physician for any illnesses, injuries, or chronic health conditions requiring treatment.
3. Conference with foster parents, caregivers, and adolescents (ie, independent living) about interval medical and mental health problems.
4. Children or teens returning from an absence without leave are at heightened risk for STDs, abuse, and neglect during their unsupervised absence. Referral of adolescents for STD and pregnancy evaluation, birth control counseling, and rape crisis evaluation and counseling should be considered as indicated.
5. Conference with receiving foster parents about interval history, with transfer of any medications, equipment, and documents.
6. Establish next appointment with primary care physician.

Return to Care After 90 Days

Children and adolescents who have been out of foster care for more than 90 days should be treated as new admissions. Health care protocols should be followed as for a new foster care admission, including the initial medical screen, comprehensive health assessment, and follow-up assessment. Medical records should be available from the prior stay in foster care. A detailed interval health history should be obtained. Children and adolescents ideally should resume care with their prior medical home while in foster care.

Visitation With Birth Parents

This encounter occurs whenever a medical intervention needs to be provided around a visit with family or relatives or screening for abuse or neglect is deemed warranted around visitations.

Purpose

1. To inform or educate the birth parents of any chronic or acute medical conditions that will require treatment during visits.
2. To screen for any signs of physical abuse on leaving and/or returning to the foster home.

Time Frame

On leaving foster home for visits and/or return from birth parents' or relatives' homes, when indicated.

Performed By

Nursing staff of child care agency or primary care physician's designated nursing staff.

Attended By

Children or adolescents, foster parents, and birth parents or family members that children or adolescents are/were visiting.

Components

1. Unclothed body inspection for suspicious bruises, welts, scratches, cuts, burns, or swelling with careful documentation and reporting, if necessary (*see* Chapter 4).
2. Conference with birth parents to inform or educate them about any chronic or acute medical conditions that will require treatment during visits.
3. Referral to health care professionals for any illnesses or injuries requiring treatment.
4. Consider public or community health nurse referral for purposes of education or assessment of birth parents.

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Internet Resources

American Academy of Pediatric Dentistry: www.aapd.org

American Academy of Pediatrics: www.aap.org

Centers for Disease Control and Prevention: www.cdc.gov

The Evan B. Donaldson Adoption Institute:
www.adoptioninstitute.org

National Clearinghouse on Child Abuse and Neglect Information,
US Department of Health and Human Services Administration for
Children & Families: nccanch.acf.hhs.gov

Recommended childhood and adolescent immunization schedule¹ — United States, July–December 2004

Vaccine ▼	Age ▶	Range of Recommended Ages					Catch-up Immunization			Preadolescent Assessment			
		Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	24 mo	4-6 y	11-12 y	13-18 y
Hepatitis B ²		HepB #1	only if mother HBsAg (+)	HepB #2									
Diphtheria, Tetanus, Pertussis ³			DTaP	DTaP	DTaP	DTaP	DTaP	DTaP					
<i>Haemophilus influenzae</i> Type b ⁴			Hib	Hib	Hib	Hib							
Inactivated Poliovirus			IPV	IPV	IPV	IPV							
Measles, Mumps, Rubella ⁵						MMR #1							MMR #2
Varicella ⁶							Varicella						Varicella
Pneumococcal ⁷			PCV	PCV	PCV	PCV	PCV						PCV
Influenza ⁸						Influenza (yearly)							Influenza (yearly)
Hepatitis A ⁹													Hepatitis A series

Vaccines below this line are for selected populations

1. Indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of April 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. ■ Indicates age groups that warrant special effort to administer those vaccines not given previously. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.org> or by telephone, 1-800-822-7967.

Health Care for Children and Adolescents in Foster Care

2. **Hepatitis B vaccine (HepB).** All infants should receive the first dose of HepB vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent HepB vaccine can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. 4 doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose except for combination vaccines, which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks. **Infants born to HBsAg-positive mothers** should receive HepB vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 24 weeks. **Infants born to HBsAg-negative mothers** should receive the first dose at 12 weeks of age. **Infants born to mothers whose HBsAg status is unknown** should receive the first dose at 12 weeks of age. **Infants born to mothers whose HBsAg status is unknown** should receive the first dose at 12 weeks of age. **Infants born to mothers whose HBsAg status is unknown** should receive the first dose as soon as possible (no later than age 1 year). The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 24 weeks.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** The fourth dose of DTaP may be administered at age 12 months provided that 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. The final dose in the series should be given at age 4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.
4. **Haemophilus influenzae type b (Hib) conjugate vaccine.** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary vaccination in infants at ages 2, 4, or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be given at age ≥ 12 months.
5. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not received the second dose previously should complete the schedule by the visit at age 11-12 years.
6. **Varicella vaccine (VAR).** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥ 13 years should receive 2 doses given at least 4 weeks apart.
7. **Pneumococcal vaccine.** The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children aged 2-23 months. It is also recommended for certain children aged 24-59 months. The final dose in the series should be given at age ≥ 12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;48(No. RR-9):1-35.
8. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥ 6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, and diabetes), health care workers, and other persons (including household members) in close contact with persons in groups at high-risk (see *MMWR* 2004;53(No. RR-4):3011-40) and can be administered to all others wishing to obtain immunity. In addition, healthy children aged 6-23 months and close contacts of healthy children aged 0-23 months are recommended to receive influenza vaccine, because children in this age group are at substantially increased risk of influenza-related hospitalizations. For healthy persons aged 5-49 years, the intranasally administered live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscularly administered live, inactivated influenza vaccine (TIV). See *MMWR* 2003;52(No. RR-13):1-8. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if 6-35 months or 0.5 mL if ≥ 35 years). Children aged ≥ 6 months who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).
9. **Hepatitis A vaccine.** Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups. Consult your local public health authority and *MMWR* 1999;48(No. RR-12):1-37. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A vaccination series during any visit. The two doses in the series should be administered at least 6 months apart.

Additional information about vaccines, including precautions and contraindications for vaccination and vaccine shortages is available at <http://www.cdc.gov/nip> or from the National Immunization Information Hotline, 800-232-2522 (English) or 800-232-0233 (Spanish). Approved by the **Advisory Committee on Immunization Practices** (<http://www.cdc.gov/nip/acip>), the **American Academy of Pediatrics** (<http://www.aap.org>), and the **American Academy of Family Physicians** (<http://www.aafp.org>).

Immunization Protects Children

Regular checkups at your pediatrician's office or local health clinic are an important way to keep children healthy.

By making sure that your child gets immunized on time, you can provide the best available defense against many of the most common and most dangerous infectious diseases. These include measles, mumps, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), *Haemophilus influenzae* type b, pneumococcal infections, and chickenpox. All of these immunizations need to be given before children are 2 years old in order for them to be protected during their most vulnerable period. Are your child's immunizations up-to-date?

The chart on the other side of this fact sheet includes immunization recommendations from the American Academy of Pediatrics. Remember to keep track of your child's immunizations—it's the only way you can be sure your child is up-to-date. Also, check with your pediatrician or health clinic at each visit to find out if your child needs any booster shots or if any new vaccines have been recommended since this schedule was prepared.

If you don't have a pediatrician, call your local health department. Public health clinics usually have supplies of vaccine and may give shots free.



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The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Practice Parameters for Developmental and Mental Health Care

Children and adolescents entering foster care typically have not experienced an environment that promotes normal growth and development. Their families have been devastated by chronic poverty, homelessness, poor education, unemployment, substance abuse, mental illness, and domestic violence. The cumulative effects of these negative life experiences are compounded by the separation, losses, and uncertainty accompanying foster care placement.

Developmental, educational, and emotional problems affect more than 80% of children and adolescents placed in foster care and are testimonies to the adversities of their prior life experiences. Some children were born prematurely, prenatally exposed to drugs and alcohol, and some have a history of trauma including abuse and neglect. These adverse experiences create a long-term developmental and mental health agenda, the resolution of which often is the key to successful permanency planning outcomes.

Successful permanency planning requires developmental and mental health treatment plans that are comprehensive, well coordinated, and ongoing. They must include the child or adolescent, birth family, and foster caregivers. Treatment plans should be designed to support the immediate goal of a stable, nurturing foster care placement and long-term goal of a successful permanent placement.

Comprehensive developmental, educational, and mental health assessment is imperative for all children and adolescents entering foster care. Assessments must be performed by professionals with expertise in developmental, educational, and mental health conditions found in infants, children, and adolescents.

This chapter describes the necessary components of comprehensive assessments and critical elements of ongoing treatment and service planning. Initial assessments must include an evaluation of the goodness of fit between children or adolescents and foster care placement. The goal is to develop treatment plans that identify appropriate treatment services that support and stabilize foster care placement.

Periodic reassessment, ongoing treatment, and service planning address all the issues critical to the development of successful permanency plans. These include children's developmental, educational, and mental health needs, guidance to foster caregivers, and support for planned permanent families.

Developmental, educational, and mental health care are discussed together because they are inextricably linked. However, these services often are provided by separate sets of health care professionals. This chapter also describes the critical importance of developmental, educational, and mental health care coordination to ensure the integration of these services.

Parameters for Developmental and Mental Health Care

Details are provided for the following events and encounters:

- Comprehensive assessment
- Treatment services
- Periodic assessments and review of the treatment plan
- Developmental and mental health care coordination

Comprehensive Assessment

Purpose

1. To identify any and all developmental and mental health conditions or disorders in children and adolescents
2. To identify strengths, weaknesses, and areas of conflict in foster caregivers' ability to support developmentally appropriate care of children and adolescents in foster care placement

3. To identify strengths, weaknesses, and areas of conflict in the families or environments of proposed permanent placements
4. To develop diagnostic formulation and treatment plans
5. To develop, with foster care staff, foster parents, and, when possible, birth parents, a shared understanding of core concerns

Time Frame

This assessment must begin as soon as possible after children enter foster care and should be completed within 30 days.

Performed By

Qualified health care professionals with expertise in the developmental, educational, and mental health conditions of children and adolescents (*see* Chapter 8).

Attended By

Children or adolescents, foster parents, caseworkers, and, when possible, birth parents. Visits by qualified health care professionals to foster care and/or birth parents' homes are optimal in assessing the families' abilities to provide developmentally appropriate care for children or adolescents.

Components

1. Developmental and educational assessment
 - Should include assessment of the following domains
 - Gross motor skills
 - Fine motor skills
 - Cognition
 - Expressive and receptive language
 - Social interactions
 - Activities of daily living (ADL) skills
 - Measurement tools are not specified here because they will vary depending on the child's age, developmental stage, and previous history. Well-standardized measures should be used.

- Developmental, educational, and mental health evaluations should include an assessment of the different homes and settings where the child or adolescent will receive care. Each state has its own system for providing these services. Health care professionals are advised to become familiar with the system in their localities.
2. Mental health assessment
 - Include a complete developmentally based mental status examination.
 - Assess family life events, circumstances of placement, and traumatic events.
 - Assess regulation of affect and behavior in different settings.
 - Assess relatedness and relationship to family members, caregivers, peers, and examiner.
 - Assess child's interests and activities.
 - Assess child's strengths and coping style.
 - Assess child's preferred mode of expression (eg, play, drawing, direct discourse) with attention to culture and ethnicity.
 - Look for signs and symptoms of
 - Risks of suicide and/or violence
 - Substance exposure, misuse, abuse, and addiction
 - Maltreatment, including physical, sexual, and emotional abuse and neglect
 - Risk of placement disruption
 - Risky sexual behavior
 - Risk of antisocial behavior
 3. Family assessment (birth and foster families)
 - Family background, composition, and household.
 - Family stressors.
 - Family's attitude toward and expectations for the child.
 - Family's strengths and weaknesses.
 - Assess need for specialized services and supports to stabilize the placement.

- Include caregiver's understanding of
 - Normal development
 - Child's specific developmental problems
 - Child's mental health needs, including effects of placement and abuse and neglect
 - Include caregiver's home environment and provision of
 - Appropriate stimulation to enhance development
 - Emotional safety, comfort, and pleasure
 - Appropriate structure, disciplinary measures, and setting of limits
4. Diagnostic formulation and treatment plan
- On the basis of the initial assessment, any identified diagnoses should be specified and a treatment plan should be developed that includes the following:
- Recommendations for treatment services for all conditions identified in the child and foster and birth families
 - Recommendations for services to enhance strengths of the child and foster and birth families
 - Recommendations for visitation with birth parents, if indicated
 - Recommendations for placement changes, if indicated
 - Recommendations for reassessment on a periodic basis
 - Identification of treatment professionals for the child and families.

Treatment Services

Treatment services should be designed to ameliorate the immediate and ongoing effects of disruption of attachments and reactions to placements in unfamiliar settings. These services should address the effect of the uncertainty that characterizes the lives of children and adolescents in foster care. Treatment must address all developmental, educational, and mental health conditions associated with biopsychosocial adversity.

Components

Treatment services may include, but are not limited to, the following:

1. Developmental/educational treatment services
 - Early intervention services
 - Special education services for preschool or school-aged children
 - Speech and language therapy
 - Occupational therapy
 - Physical therapy
 - Services for the hearing or visually impaired
2. Mental health services
 - Psychotherapies such as individual, group, and cognitive-behavior therapy and social skills training.
 - Psychopharmacologic treatment (*see* Chapter 6) can be an important component of mental health services. This treatment is used in conjunction with other therapies and requires careful psychiatric assessment and monitoring. Regular medical and laboratory assessment is indicated by the specific psychotropic medication used.
 - Substance abuse treatment.
 - Family services including family therapy, parenting guidance, couples therapy, and individual therapy for caregivers.
 - Specific individual or group training for caregivers on topics such as behavior management, normal and abnormal development, and special problems of foster placement (eg, effects of disrupted attachments or abuse and neglect).
 - Peer-support groups for children or adolescents specifically related to issues of foster care placement such as separation and loss, loss of autonomy and control, and sexual abuse.

Periodic Assessments and Review of the Treatment Plan

Purpose

1. To ensure the continuing effectiveness of treatment services
2. To make necessary changes in the treatment plan to reflect patterns of normal development

3. To reevaluate treatment needs in anticipation of or response to critical junctures or transitions in foster care placement, which include, but are not limited to,
 - Disruptions or lapses in visitation with natural family
 - Termination of parental rights
 - Adoption or discharge from foster care
 - Separation from or reunion with siblings
 - Death or severe illness of foster caregivers or birth families
 - Uncovering or disclosure of abuse
 - Incarceration of a parent
 - Changes in foster care placement

Time Frame

Whenever critical junctures occur in the placement life of children in foster care. For all children younger than 3 years, reevaluations should occur at 6 months, 18 months, and 2 years of age. They should occur at least yearly for all children 3 years and older.

Performed By

Qualified health care professionals with expertise in the developmental, educational, and mental health conditions of children and adolescents.

Attended By

Children or adolescents, foster parents, caseworkers, and, when possible, birth parents. Visits by qualified health care professionals to foster care and/or birth families' homes are optimal in assessing the families' abilities to provide developmentally appropriate care for children or adolescents.

Components

1. Review of interim history in all areas evaluated during the comprehensive assessment.
2. Evaluation of progress reports from all health care professionals providing treatment services, including interval reports from school personnel.

3. Selective reevaluation of areas suggested by interim history as determined by the care coordinator and performed by qualified health care professionals.
4. Modification of diagnostic formulation and/or treatment plan as indicated by this review and/or reevaluation.
5. Reassessment of family milieu, strengths, and weaknesses. This is particularly important in situations in which there has been a change in foster home placement or permanency plan.

Developmental and Mental Health Care Coordination

The assessment of developmental and mental health conditions and provision of needed treatments is an especially complex process for children and adolescents in foster care. Multiple factors, including children's ages and developmental stages, complexities of the children's life experiences, and issues related to permanency planning, affect the care of children and adolescents in foster care. An assessment plan cannot be specified until consideration of these issues plus a review of any prior evaluations has been completed. Specialists also have to work with multiple other health care professionals and complex family structures, as well as work within the confines of foster care regulations for consent and confidentiality. Therefore, a health care coordinator who is a professional trained in the field of developmental and mental health care is essential to determine the plan of assessments and coordinate the treatment of these children and adolescents.

Care coordination at the level of developmental or mental health services is critical to executing agencies' services and ensuring effective, frequent communication and collaboration between foster care agencies (via health care management and caseworkers), birth families, foster families, and primary care physicians. Care coordination is similar to but distinct from the role of health care management at foster care agencies (*see* Chapter 5), which oversees all aspects of

children's health care. There must be frequent, effective communication and collaboration between the two.

Purpose

1. To coordinate and arrange for comprehensive assessment of the individual child based on his or her age and review the history, including any prior evaluations
2. To coordinate and arrange for all treatment services recommended by the comprehensive assessment
3. To arrange for periodic reassessments and reviews
4. To ensure that the foster family and, when appropriate, birth family are educated about the child's and family's developmental, educational, and mental health needs
5. To ensure coordination and communication among all developmental, educational, and mental health care professionals
6. To communicate and coordinate care with the foster care agency through health care management (*see* Chapter 5)

Time Frame

Ongoing.

Performed By

Qualified health care professionals with expertise in the developmental, educational, and mental health conditions of children and adolescents (*see* Chapter 8).

Components

1. Acquiring information
 - Acquiring all information relevant to developmental, educational, and mental health conditions such as, but not limited to,
 - Birth family history of mental illness or developmental condition
 - History of psychosocial issues prior to placement
 - Previous developmental, educational, and mental health assessments and treatments, if any
 - School performance

2. Determining assessment services required and coordinating recommended treatment services
 - Review all available information.
 - Determine assessments required.
 - Coordinate referrals for developmental, educational, and mental health evaluations and services.
 - Ensure that all recommended treatment services are obtained, including referrals.
3. Follow-up services

Ensure that all periodic reassessments and reviews are conducted according to protocol, including any reassessments or additional developmental, educational, and mental health services needed as the result of significant changes in placement or disruptions in care.
4. Providing care coordination
 - Ensure that summaries of assessment findings are prepared and sent to health care management at the foster care agency (health care management is then responsible for further distribution of these reports).
 - Prepare summaries of treatment recommendations and progress and share these with health care management.
 - Act as the primary communication link between health care management at the foster care agency and developmental, educational, and mental health care professionals.
 - Provide coordination for all services required to support the goals of the developmental, educational, and mental health services plan including early intervention, school-based, and vocational services.
 - Provide summary reports and recommendations to the foster care agency for continued use of developmental, educational, and mental health services as part of the after-care plan.

5. Health education for families
 - Explain all findings and treatment service recommendations to the child or adolescent, his or her foster family, and, when appropriate, the birth family.
 - Respond to inquiries about developmental, educational, and mental health issues from the foster family, birth family, or child or adolescent.
 - Respond to inquiries about developmental, educational, and mental health issues from the foster care agency, primary care physician, and educational professionals.

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Internet Resources

American Academy of Child and Adolescent Psychiatry:
www.aacap.org



Practice Parameters for Child Abuse and Neglect

Upward of 70% of children and adolescents entering the foster care system have been physically abused and neglected and/or sexually abused prior to foster care. It is mandatory that children and adolescents entering foster care be screened for a history or signs or symptoms of abuse and neglect. At entry, the local commissioner of social services has the obligation of ensuring the safety and well-being of children and adolescents in foster care. Because children and adolescents may be victimized in their foster placements or during visitation with their parents or relatives, continued monitoring for signs and symptoms of abuse and neglect while in care also is essential. It is particularly important to monitor the quality of the relationship between children and adolescents and their foster and birth parents; this is especially true for children who are preverbal or developmentally delayed because they are more likely to be victimized. Child abuse and neglect screenings and evaluations need to be conducted in a timely fashion by an experienced health care professional.

Two types of child abuse and neglect visits are discussed in this chapter. Medical screening for child abuse should be a part of every medical encounter with children and adolescents in foster care. Health care professionals who work with these children must be skilled in identifying indicators of child abuse and neglect.

More detailed medical child abuse evaluations should be conducted whenever there is suspicion of physical or sexual abuse or neglect. Child abuse evaluations are best conducted by a team of expert professionals (ie, child abuse team or center) to minimize the trauma

to children, maximize documentation, and ensure appropriate treatment and referrals. A single comprehensive evaluation for child sexual abuse should be conducted by the most experienced available professional(s) to avoid the trauma of multiple interviews and examinations.

In addition to a brief description of child abuse and neglect screening and evaluation, this chapter provides a format for triaging children and adolescents who are suspected of being victims of sexual abuse and steps to take if abuse or neglect is suspected.

Parameters for Child Abuse and Neglect

Child Abuse and Neglect Screening

Purpose

1. To ensure the safety of the child or adolescent
2. To identify signs or symptoms of abuse and neglect, including but not limited to behavioral indicators such as enuresis, encopresis, nightmares, sexual knowledge inappropriate for the child's age, and sexualized behaviors
3. To obtain appropriate medical treatment for children or adolescents who have been abused and neglected; in particular, to identify children who need acute medical or mental health intervention
4. To involve the appropriate authorities, including child protective services (CPS) and law enforcement
5. To communicate information obtained from the examination to the agency with care and custody of the child

Time Frame

- At entry into care as part of the admission screen.
- Child abuse and neglect screening is part of every health encounter.
- Whenever there is concern expressed by the foster or birth parents, any caregiver, or any health care professional involved with the child.

- At return to foster care from discharge or from an absence without leave.
- At return from unsupervised visitation, if a concern is raised.
- At discharge from foster care.

Performed By

Screening interviews and examinations may be performed by *qualified* agency medical personnel or the primary care physician. An impartial party should screen children or adolescents alleging abuse by agency personnel.

Attended By

This will vary depending on individual circumstances. The health care professional should be guided by the comfort and safety of the child.

Components

Child abuse and neglect screening should be incorporated into health care encounters in ways that are sensitive to the child's fears and anxieties and yet allow the identification of physical findings and provide sufficient information to determine if further evaluation is warranted.

1. Interview—a brief, problem-focused private interview of the child, if appropriate
2. Observations to include
 - Child's affect
 - Height and weight (and head circumference if younger than 3 years)
 - Skin examination for bruising, burns, or other signs of trauma; the examination should include nails and hair
 - Range of motion of joints and extremities
 - Genital and anal survey, if indicated, for bruising, lacerations, burns, bleeding, discharge, and integrity of the tissues

Child Abuse and Neglect Evaluation

Purpose

1. To ensure the safety of the child
2. To identify signs and symptoms of abuse and neglect
3. To document findings of abuse and neglect
4. To obtain appropriate medical treatment for children who have been abused and neglected; in particular, to identify children who need acute medical intervention
5. To appropriately refer children who have been abused or neglected for mental health care services; in particular, those in need of acute mental health intervention
6. To involve the appropriate authorities, including CPS and law enforcement
7. To communicate information obtained from the interview and evaluation to the agency with care and custody of the child

Time Frame

This will depend on the acuity of the issue that has been identified. Immediate evaluation should occur when there is

- A disclosure by the child.
- The presence of any indicators of child abuse and neglect on screening.
- Any child or adolescent identified as a perpetrator of sexual abuse.
- Any child residing in the same home as an identified victim of child physical or sexual abuse or neglect.
- Concern of abuse raised by the foster or birth parents, any caregiver, or any health care professional involved with the child.

Performed By

Evaluations should be performed by health care professionals trained and experienced in child abuse. Specialized professional examinations minimize trauma for the child and maximize documentation. A complete examination for child sexual abuse should be performed by the most highly skilled medical professional available. Multiple

interviews and/or examinations should be avoided to minimize trauma to the child. An impartial party should evaluate children or adolescents alleging abuse by agency personnel.

Components

1. Interview by the most skilled interviewer available; interview should be conducted with the child privately, following guidelines developed by the American Professional Society on the Abuse of Children (*see* “Internet Resources” under “Bibliography” in this chapter).
2. Observation of affect.
3. Height and weight (and head circumference if younger than 3 years).
4. Thorough directed physical examination including skin, nails, hair, mouth, extremities, genitalia, and anus.
5. Documentation, including sketches, and a detailed descriptive narrative; appropriate photographic documentation is strongly recommended.
6. Imaging and laboratory studies as clinically indicated.

Child Sexual Abuse—Triage and Evaluation

Purpose

1. To ensure the safety of the child
2. To identify signs and symptoms of child sexual abuse, including but not limited to nightmares, enuresis, encopresis, sexual knowledge inappropriate for the child’s age, and sexualized behaviors inappropriate for age
3. To document findings of child sexual abuse
4. To obtain appropriate medical treatment for children who have been sexually abused; in particular, to identify children who need acute medical intervention
5. To appropriately refer children who have been sexually abused for mental health care services, especially those in need of acute mental health intervention

6. To involve the appropriate authorities, including CPS and law enforcement
7. To communicate information obtained from the examination to the agency with care and custody of the child

Time Frame

This will depend on the acuity of the issue identified (*see* “Components” below).

Performed By

Evaluations should be performed by health care professionals trained and experienced in child sexual abuse evaluations. Specialized evaluations minimize the trauma for the child and maximize documentation. Multiple interviews and/or examinations should be avoided to minimize trauma to the child. An impartial party should evaluate children or adolescents alleging abuse by agency personnel.

Components

1. Emergency evaluations for child sexual abuse—same day
 - Criteria
 - History of sexual abuse occurring within preceding 72 hours
 - Vaginal or rectal bleeding, pain, or trauma within preceding 72 hours
 - Where
 - Child abuse team or center is preferred at all times because of the specialty training of the personnel.
 - In lieu of a child abuse team or center, the most highly skilled available health care professional is the next most acceptable choice. This is likely to be the staff of the pediatric emergency department. In some cases, pediatricians or gynecologists with appropriate child sexual abuse training may be alternatives.

2. Urgent evaluations for child sexual abuse—within 2 to 5 days
 - Criteria
 - Abuse occurring within the last 3 to 14 days and the child is living in a safe environment
 - The presence of vaginal discharge or suspicion of a sexually transmitted disease, even if the exact timing of the abuse is unknown
 - Where
 - The preferred health care professional is a regional child abuse team or center.
 - Ambulatory care facilities capable of such evaluations. This may include pediatricians or gynecologists with appropriate child sexual abuse training and experience. (A child abuse team or center is preferred.)
3. All other child sexual abuse evaluations—within 2 weeks
 - Criteria
 - Abuse occurring more than 10 to 14 days in the past and the child is living in a safe environment
 - Any child residing in the same home as a child diagnosed as a victim of child sexual abuse
 - Any child who sexually approaches another child
 - Any child who is identified on screening or examination as having behavioral or physical indicators of child sexual abuse
 - Where
 - A child abuse team or center is always the preferred health care professional.
 - Ambulatory sites with personnel having appropriate child sexual abuse training and experience are adequate. (A child abuse team or center is preferred.)

Steps to Take if Child Abuse or Neglect Is Suspected

- The safety and well-being of the child is the primary concern; the child must have a safe place to live.
- A CPS referral must be made whenever child abuse and neglect inflicted by a person in a caregiving role are suspected. Health care professionals are mandated reporters. Law enforcement most likely will need to be notified. Health care professionals should familiarize themselves with the reporting system in their own states.

Write in your local reporting system information here.

- Notify the child's caseworker or agency; communicate the results of the screening or evaluation to the caseworker or agency.
- History and physical findings must be thoroughly documented.
- A single comprehensive child sexual abuse evaluation should be conducted by professionals trained and experienced in sexual abuse in a setting that is quiet and comfortable for the child. In lieu of a child abuse team or center, the examination should be conducted by the most highly skilled health care professional available.
- The child should receive whatever medical care is deemed necessary in a timely fashion.
- Appropriate referral for counseling should be made.

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Internet Resources

American Academy of Pediatrics: www.aap.org

American Professional Society on the Abuse of Children:
www.apsac.org



Health Care Management

Foster care agencies are bound by law to ensure that children and adolescents in foster care receive services necessary to optimize their physical, emotional, and developmental well-being. While holding agencies responsible, the law does not specify how agencies are to accomplish this. Traditionally, agencies have relied on caseworkers to serve as case coordinators for medical, mental health, dental, and developmental issues; caseworkers, in turn, rely on foster parents to serve as children's advocates with medical, mental health, dental, educational, and developmental systems of care. However, numerous studies (*see* Chapter 1) demonstrate that children and adolescents in foster care have multiple physical, emotional, and developmental needs that are inadequately addressed by this traditional reliance on caseworkers and foster parents as health care coordinators. In fact, there are no studies indicating that this has ever been a successful approach.

There are multiple barriers to successful health care coordination in the foster care system. First, children and adolescents in foster care have multiple, complex health care needs that demand a high level of medical sophistication on the part of health care professionals. Except in unusual circumstances, caseworkers and foster parents do not possess the medical knowledge and familiarity with the intricacies of the health care system to perform this function adequately. The level of sophistication required to coordinate health care services for children and adolescents in foster care is most similar to that of case managers for children with special health care needs. The second major barrier is the highly mobile and transient nature of the population, which makes maintaining children and adolescents in medical homes and timely transfers of medical

information formidable tasks. Third, the lack of medical and financial resources to adequately provide for this group limits access to the type and range of services necessary for many children and adolescents in foster care. The fourth obstacle is the complexity of the foster care bureaucracy itself, which impedes information sharing. Shared responsibility for these children and adolescents among foster parents, birth parents, and caseworkers is inherent to the system but creates opportunities for miscommunication, conflict, and the abrogation of responsibility. Another significant barrier to optimal health care coordination is lack of information about these children and adolescents as they enter the foster care system and the difficulties of maintaining accrued information in an accessible and useful form even after children and adolescents have entered care. Requirements around consent and confidentiality are complex, further contributing to the difficulty of information gathering and sharing.

In response to the legal mandate for foster care agencies to provide for the optimal physical, emotional, and developmental health of children and adolescents in foster care and in recognition that the traditional approach has failed to overcome barriers to high-quality, comprehensive, and coordinated health care for this vulnerable and needy population, a new approach—*health care management*—is necessary for children and adolescents in foster care.

The phrase *health care management* is used in this manual to refer to the functions that must be in place to ensure that children and adolescents in foster care receive high-quality, comprehensive, and coordinated health care. *Health care management is the responsibility of the child welfare agency, but it is a function that requires medical expertise.* Health care management requires a structure apart from traditional casework and medical roles.

As noted in Chapter 1, it is anticipated that different agencies will have different solutions or models that will satisfy the standards for health care management. Some agencies may choose to delegate some part of the health care management function to primary care physicians or public health nurses. Agencies are, however, ultimately responsible for ensuring that all of these health care management functions are carried out in a consistent and thoughtful manner for each and every child and adolescent in their care.

Agencies may have a single individual or team performing health care management functions. The individual, or at least one member of the team, must be a physician, pediatric or family nurse practitioner, or registered nurse. The individual, or at least one member of the team, also must have experience in working with the pediatric population, familiarity with foster care, and effective communication, managerial, and advocacy skills.

The functions of health care management include

- Information gathering, which includes organizing and maintaining health-related information in a complete, succinct, and useful manner.
- Ensuring that appropriate medical consents are available.
- Coordination of health care services, which includes ensuring children and adolescents have access to health care, monitoring children's use of the health care system, and ensuring that children receive services appropriate to their health care needs. Coordination also includes systematic communication and coordination of care among medical personnel, casework staff, and foster and birth parents. Health care coordination includes an advocacy role to ensure that children and adolescents receive all necessary health, mental health, and developmental services in a timely manner.

- Educating foster care agency staff, legal staff, educators, and foster and birth parents about health care issues pertinent to the care of children and adolescents; educating health care professionals about foster care issues that affect the health of children and adolescents.
- Ensuring that medical plans for children and adolescents are integrated into permanency plans for them by foster care agencies.

Information Gathering

Obtaining Past Medical History

Health care professionals and foster care staff need past health care information to create a plan for children and adolescents and to ensure that all of their health needs are met. Health care management, often in collaboration with other agency staff and primary care physicians, will attempt to obtain as much past health care information as possible about children and their families (*see* Chapter 2). If at all possible, it is important that agency staff interview the children and adolescents and/or birth parents to gather this information. Whether an interview is possible, agency or medical staff should use other routes to identify past sources of health care and obtain the medical history. While this task should be accomplished as soon as possible after children enter foster care, the difficulties associated with obtaining consents and locating prior sources of care often dictate that it is an ongoing process while children are in care. Obtaining consents and locating medical information are labor-intensive, time-consuming processes, but are of the highest priority.

Establishing the Medical File

Each child and adolescent in foster care must have a medical file in which all relevant medical information, past and ongoing, will be placed. The medical file may be paper or electronic and is the centralized medical information resource for the agency. Health care management is responsible for obtaining, organizing, and

maintaining this file in a concise and useful manner. These files, which are agency-based, are separate from the medical record that is maintained by each health care office that provides services to the child. Each agency will be responsible for deciding the format and details of the content, but the file at least should contain

- Updated problem list
- Updated medication list
- Updated immunization record
- Appropriate consent documents
- Summaries of ongoing health care visits to the primary care physician
- Complete past medical history
- Summaries of ongoing health care visits to medical subspecialists
- Human immunodeficiency virus (HIV) risk assessment documentation and any HIV-related information
- Developmental and mental health evaluation summaries
- Educational evaluation summaries
- Summaries of developmental and mental health treatment plans
- Laboratory reports
- Summaries of health care planning conferences

In the situation in which an agency has its own medical office providing the full range of pediatric primary care services outlined in this manual, the medical chart may fill the dual role of medical file and medical record as long as the information is accessible to child welfare personnel.

Information Management

Quality health care management generates data. These data allow for tracking and the confidence that all health care service needs are identified and met. Agencies must develop systems that organize and store that data. Health care management must ensure that information is conveyed to the data information system that has

been established. In some cases, the data information system will be a direct responsibility of the health care management team. In others, there may be a separate structure that will need to be updated, monitored, and integrated. The data must be retrievable in several formats. The agency must be able to retrieve data about an individual child. The agency also must be able to aggregate data for all children so that they can produce reports for review by local district commissioners and state agencies with oversight responsibilities.

Obtaining Medical Consents

Agencies must make good faith efforts to obtain written consent from birth parents for regular, recurring medical treatment (*see* Chapter 6). While it is not the express responsibility of the health care manager to obtain this consent, health care management must ensure that written consent is obtained and a copy of the consent is placed in the medical file and shared with the primary care physician.

If it is not possible to obtain written consent when a child or adolescent is placed in foster care, health care management staff must make ongoing requests of the foster care agency staff to obtain consent. The absence of written consent should not delay or defer seeking routine or urgent health care for the child (*see* Chapter 6).

Foster care agency staff should work with health care management to ensure that appropriate consent has been received for specific health care interventions for which it is required. In those situations in which interaction with the health care professional is critical to the consent process, the health care manager must coordinate plans among the foster care agency staff, physician, foster parents, birth parents or legal guardians, and children or adolescents to ensure that consent truly is informed (*see* Chapter 6).

Health Care Coordination Role

Health care management has a vital role in ensuring that each child and adolescent in foster care receives all necessary medical, developmental, and mental health care services while in foster care, the foster parents are compliant with the medical plan for the child, and information is shared appropriately among health care professionals involved in the child's care.

Ensuring Compliance With Health Standards

Health care management is responsible for identifying children and adolescents who come into foster care to the medical team and a primary care physician or medical home for each child entering the system. This implies that the foster care agency is responsible for identifying children and adolescents entering care to health care management.

Health care management is responsible for ensuring that each child and adolescent who enters foster care has an initial medical screen, a comprehensive health assessment visit, and a follow-up health assessment visit as part of the admission process to foster care (*see* Chapter 2). The child may receive these services through the agency's medical office, if one exists, or from his or her primary care physician. Ideally, these visits occur with the health care professional who will be the ongoing medical home for the child while in foster care.

Health care management is responsible for ensuring that each child and adolescent in foster care receives routine preventive health care services according to health guidelines for children in foster care (*see* Chapter 2). These services should occur in the medical home.

Health care management is responsible for ensuring that the child or adolescent is referred in the time frame indicated for comprehensive developmental and mental health evaluations (*see* Chapter 3). In some instances, these evaluations will occur at the same time and

locale as the comprehensive health assessment. For most children, the comprehensive mental health and developmental evaluations will occur at different times and with different health care professionals in different locations.

For children and adolescents not enrolled in ongoing mental health and developmental services, health care management must ensure that periodic reassessments of their emotional and developmental needs are conducted. For children enrolled in ongoing developmental and mental health care services, health care management must communicate with care coordinators for those services. Developmental and mental health care coordinators determine what assessments are required and coordinate the assessment and treatment activities of developmental and mental health specialists (*see* Chapter 3). The developmental and mental health care coordinators explain the developmental and mental health findings and treatment plans to everyone involved in the children's care. This role complements but does not replace that of health care management at foster care agencies.

The health care manager is responsible for ensuring that children suspected to be victims of physical abuse or neglect or sexual abuse receive appropriate evaluations and health care and foster care agency personnel have made appropriate referrals (*see* Chapter 4).

Health care management is responsible for ensuring that children and adolescents in foster care receive appropriate medical services for

- Acute illnesses.
- Chronic medical needs, including those requiring subspecialty referral. For children and adolescents with complex health care needs, health care management is responsible for arranging, coordinating, and monitoring appointments with individual health care professionals, even when a care coordinator is involved.

- Emotional health conditions.
- Developmental delays.
- Transfers or changes in foster care placement.
- Return to foster care.
- Child abuse and neglect allegations while in foster care.
- Discharge from foster care.

Monitoring Foster Parent Compliance

Health care management is responsible for ensuring that

- Foster parents are aware of the health care requirements.
- Foster parents attend all scheduled health care appointments.
- Foster parents attend all health care conferences when their presence is indicated.
- Missed appointments are rescheduled.
- Concerns about the foster parents are shared with the foster care agency and health care professionals.

Noncompliance of the foster parents with the medical, mental health, and developmental planning for a child in foster care is a serious breach of parenting responsibility and must result in agency intervention with the family. It is the responsibility of the health care team to monitor foster parent compliance and inform the agency of lapses in compliance.

Information Sharing and Care Coordination

A critical function of health care management is the coordination and linkage of health care services among different health care professionals and agency staff. This is particularly important when the interaction includes behavioral and developmental health care professionals. Links also must be forged and maintained between health care professionals and children and adolescents, foster parents, birth parents, and agency staff. The health care manager is responsible for ensuring that information sharing occurs in such a way as to enhance the coordination of health care services.

Information that is gathered must be reviewed for

- Completeness
- Identification of health care conditions
- Recommendations for further treatment
- Appropriateness of ongoing services
- Alternative treatment options

After reviewing health care information, health care management may wish to

- Consult with health care professionals, agency staff, the child or adolescent, foster parents, and/or birth parents to seek further information or to develop or explain the health care plan.
- Consider obtaining a second opinion in certain situations.

After reviewing the information, health care management must

- Share information promptly with agency personnel, the primary care physician, and other health care professionals as indicated.
- Ensure that foster parents are informed of and understand the information.*
- Communicate information to the birth parents.*
- Assist foster parents in obtaining appropriate referrals.

**See Chapter 7 for a further discussion of what types of information may and may not be shared with foster caregivers and birth parents.*

Integration of the Health and Child Welfare Plans

The ultimate goal of health care management is to develop a comprehensive treatment plan in collaboration with caseworkers and primary care physicians that uses all known pertinent health information and takes into consideration permanency plans for children and adolescents, strengths and weaknesses of current foster care placements, and psychosocial needs of children and adolescents. This integration of health and social service agendas is the crux of quality health care management for this population. The health

care manager is responsible for assisting the agency in integrating health care information into the permanency planning for the child or adolescent.

Other Health Care Coordination Functions

- Assist foster care personnel with finding appropriate foster homes for children with complex health, developmental, and behavior problems.
- Assist the agency with ongoing training for foster parents designated to provide care for children who are medically complex or fragile.
- Assist foster care personnel with compiling medical information for subsidy assessment.
- Compile medical information for use by agency personnel in routine court hearings.
- Assist with release of medical information under subpoena.
- Ensure health insurance is activated in a timely manner; when necessary, ensure rapid enrollment or disenrollment and transfer of insurance for a child who changes placement or agencies.
- Ensure that medical information is transferred to the new primary care physician when a child is transferred between agencies or discharged from foster care.

Education

Health care management should participate in the education of foster care agency personnel, foster parents, children and adolescents in foster care, and birth parents. Education should cover agency health care requirements for children and adolescents in foster care in general, as well as specific treatment plans for individual children and adolescents. Health care management must be able to communicate in language understandable to a layperson. Education must be integrated into interactions with staff and families that occur informally, as well as at scheduled planning conferences. Some agencies may choose to use

the health care management team to conduct or organize on-site training sessions. Specific topics will vary but may include the following:

- Delineate preventive health care requirements for children and adolescents in foster care.
- Consent and confidentiality procedures.
- Medical procedures that must occur at home (eg, nebulizer use).
- Role of home health agencies for health care and training.
- Medication delivery, storage, and safety.
- Child development.
- Explain child behavior in the context of developmental stages.
- Effects of foster care on children and adolescents.
- Effects of abuse and neglect on children and adolescents.
- Describe the behavioral and physical indicators of abuse and neglect.

Health Care Professionals

Health care management also is responsible for familiarizing health care professionals with the effect of the foster care system on children and foster and birth parents, especially concerning issues of separation and loss and the long-term impact of abuse and neglect. Education also should include information about the mandates and agendas of the foster care system and consent and confidentiality issues unique to foster care.

Summary

Health care management is vital for children and adolescents in foster care to achieve wellness and permanency. It is recognized that other factors, such as the emotional well-being and maturity of birth parents, their compliance with visitation and other recommendations of family court and child welfare staff, and the ability of foster parents to meet children's needs, have a much more profound effect on child and adolescent well-being. However, promoting

adherence to health care standards and improving communication among the various parties involved in children's care will improve the overall quality of health care and decrease the fragmentation of health care services. Educating foster and birth parents about health issues and providing an additional level of support will stabilize foster care placements and enhance caregiver skills. That, in turn, should result in better outcomes and earlier achievement of permanency for children and adolescents in foster care. The health care management role demands health expertise beyond that of foster care personnel and foster parents and should be viewed as a support service for both. Health care management is the mechanism for integrating health and social services planning in a way that enhances health outcomes, well-being, and permanency for this most vulnerable and needy population.



Medical Consents for Children and Adolescents in Foster Care

This chapter is not designed to be an exhaustive discussion of medical consents for children and adolescents in foster care, but rather an introduction and a guideline. This is a complex area, governed by clearly defined legislation and regulations that vary from state to state. In addition, foster care agencies have developed individual policies interpreting these laws and regulations. Health care professionals are advised to become familiar with the policies of their particular agencies and contact an administrative or legal official at the agencies when questions or concerns about consents arise. If agencies have a health care management team, the administrator of that team should be able to offer health care professionals guidance on consent issues.

In this chapter, birth parents refers to birth parents and legal guardians, and agencies includes private foster care agencies and local social service agencies.

General Principles Governing Medical Consents

Children and adolescents in foster care are in the care and custody of local or state commissioners of social services. Legal guardianship remains with birth parents unless children are freed for adoption.

Generally speaking, the local or state commissioner of social services has the ability to consent for routine medical treatment for children and adolescents in foster care, either because of statute or because the birth parents signed a general medical consent giving the commissioner this authority.

Commissioners are committed to the principle that, whenever practical or possible, the birth parents of the child or adolescent should make all-important decisions and grant consent on behalf of their child. At individual agencies, policies usually are in place requiring the agencies to ask birth parents to give consent for medical care, so as to involve them in the health care needs of their children. However, if birth parents are unavailable or uncooperative, then by statute or previously signed general medical consents, agencies can approve medical procedures for which written consent is required and which are deemed to be in the best interests of children or adolescents. Best practice is to make sure that the agencies and birth parents are aware of and have specifically consented to medical procedures requiring informed consent.

Commissioners may delegate the authority for medical consent to other child welfare personnel. Agencies vary as to who has the authority to consent for medical care. Generally, caseworkers would have to seek at least supervisory authority for any medical procedure requiring written consent. Any procedure normally requiring informed consent would require the consent of an administrative figure or committee in lieu of the birth parents. Sometimes agencies may take a matter before a judge when birth parents oppose a medical intervention deemed to be in the best interests of children or adolescents.

Generally, foster parents do *not* have the authority to provide consent for medical procedures and are required to seek approval from agencies.

Frequently Asked Questions

This information varies from state to state; health care professionals are urged to contact their state foster care agencies to determine the guidelines for their own states.

Who May Give Medical Consent for Children and Adolescents Freed for Adoption?

When children or adolescents have been freed for adoption (voluntarily by parents or involuntarily through termination of parental rights), they no longer have parents with any legal rights, and the local or state commissioner becomes their legal guardian. Only the commissioner or designated child welfare personnel can consent for medical procedures on behalf of children or adolescents freed for adoption.

Who May Give Consent for Human Immunodeficiency Virus Testing for Children and Adolescents in Foster Care?

There are specific and quite detailed procedures in regulations and individual agency policy for consent for human immunodeficiency virus (HIV) testing of children and adolescents in foster care, and these vary from state to state.

Who May Give Consent for Reproductive and Related Services for Children and Adolescents in Foster Care?

In some states, if a health care professional determines that a minor has the capacity to consent, the physician must seek the consent of the minor for medical services related to reproductive health, sexually transmitted diseases, HIV testing, and substance abuse. This is similar to how a physician would handle these circumstances for a minor not in the foster care system. The health care professional is advised to discuss this issue with his or her state health department. Foster care regulation may differ from state health law on this topic, and the health care professional should seek guidance as to which takes precedence.

How Does the Status of a Child or Adolescent in Foster Care Affect Who May Give Consent?

Most children and adolescents are in *involuntary foster care placement* for reasons of child abuse or neglect. While birth parents may give

consent for medical procedures in such circumstances, consent always should be obtained from agencies in addition to or in lieu of birth parents. The agencies always should attempt to engage birth parents in these issues.

For children who are in *voluntary foster care placement* or placed because of Person in Need of Supervision (PINS) or juvenile delinquency status, the birth parents or agencies may provide consent. In these situations, agencies attempt to seek consent from birth parents. However, agencies should have obtained a general medical consent at the time of placement and may consent on behalf of children, if necessary.

Only agencies may consent for medical care for children freed for adoption. In some instances, adults between the ages of 18 and 21 years may still be in foster care, and agencies may have specialized consent policies for them.

Are There Situations in Which Consent of Birth Parents Is Not Required, Even for Children and Adolescents in Voluntary, PINS, or Juvenile Delinquency Placement?

The consent of birth parents is not required if the time necessary for seeking consent would present a danger to the life, health, or immediate welfare of a child or adolescent, or a physician believes this to be the case.

How Does the Category of Medical Care Affect Whether Written Consent Is Required?

Specific written consent may not be required in some states for

- Urgent medical care, described as medical, mental health, and dental services that must be instituted immediately to prevent danger to a child's life
- Services customarily given as part of preventive health care and care for ordinary childhood diseases and illnesses

Efforts always should be made to inform all interested parties about such care (eg, foster parents, birth parents, agency personnel).

Specific written consent is, in general, required by most states for

- Nonurgent or elective medical care described as elective medical and dental services that are not customarily given as part of preventive health care. This includes any service or intervention requiring informed consent (eg, surgery, chemotherapy, contrast agents, anesthesia). Health care professionals should contact administrative or legal personnel at foster care agencies when written consent is indicated.
- The prescription of psychotropic medication requires written consent for each individual medication.
- Mental health agencies usually require specific written consent for performing evaluations and providing services.

Are There Any Particular Safeguards That Health Care Professionals Should Undertake Concerning Consent for Medical Care for Children and Adolescents in Foster Care?

Primary care physicians should be provided with a copy of general medical consents for children and adolescents in foster care or should seek copies of them from foster care agencies.

For procedures or interventions requiring specific written consent, health care professionals always should contact administrative, legal, or health care management personnel at foster care agencies. It is then the agencies' responsibility to facilitate the consent process.

It is prudent to document any specific discussions about medical consent for a procedure or intervention in the patient's chart.

What if a Child or Adolescent in Foster Care Needs Medical Intervention Requiring Consent After Hours or While on a Holiday?

There always should be someone available from foster care agencies 24 hours a day, 7 days a week. Health care professionals are advised to contact the agencies.

Who Is the Consenting Party for the Medical Care of the Offspring of Adolescents in Foster Care?

If an adolescent is in foster care and has custody of his or her child who is not in foster care, the adolescent is the consenting party.

If the adolescent and his or her child are both in foster care and the adolescent resides with the child, either the adolescent or the agency may give consent, but the health care professional is advised to seek guidance from the agency about consent on behalf of the child.

If the adolescent and the child are both in foster care, but the child resides apart from the adolescent, the same rules apply as for other involuntary placements. The health care professional should contact the agency about consent.

Who Has Legal Guardianship When Children or Adolescents Are Placed With a Relative Resource (Often Called Kinship Care)?

Most often, legal guardianship continues to reside with birth parents unless there has been a court process transferring legal guardianship. If relatives indicate they have legal guardianship, they should have a document from the court stating that this is the case. Health care professionals should contact the agencies to clarify guardianship and the process for obtaining consent for health care.

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Confidentiality

This chapter is not designed to be an exhaustive discussion of confidentiality issues for children and adolescents in foster care, but rather an introduction and a guideline. This is a complex area governed by clearly defined legislation and regulations that vary from state to state. In addition, foster care agencies have developed individual policies interpreting these laws and regulations. Health care professionals are advised to become familiar with the policies of their particular agency or contact an administrative, legal, or health care management official at the agency when questions or concerns about confidentiality issues arise.

Health care professionals always have to weigh their patients' rights to privacy and legally protected confidentiality against the needs of other individuals involved in the care of their patients to know information to facilitate health care. This is particularly true in areas such as human immunodeficiency virus (HIV) testing or infection, sexuality, mental health, substance abuse, and family medical history.

In this chapter, birth parents refers to birth parents and legal guardians, and agencies includes private foster care agencies and local social service agencies.

The Health Insurance Portability and Accountability Act (HIPAA) applies to children and adolescents in foster care, and it is assumed that health care professionals are in compliance with HIPAA. The information in this chapter is specific to foster care.

Frequently Asked Questions

Who Has Access to Medical Information Concerning Children and Adolescents in Foster Care?

Health care professionals should assume that all medical information is confidential. In addition, they should assume that confidentiality extends to names, addresses, and phone numbers of children and adolescents, foster parents, and relatives. Medical information may be shared with caseworkers, other designated agency personnel, and foster parents (some exceptions to this are noted in the next question and answer). Health care professionals should check with administrative or legal personnel at foster care agencies before releasing information to birth parents.

Are There Any Exceptions to Sharing Medical Information With Caseworkers and Foster Parents?

In general, caseworkers and foster parents have access to all medical information about children and adolescents in foster care for whom they are responsible, except in the following cases:

- Health care professionals should assume that minors with the capacity to consent have the right to absolute confidentiality for issues related to family planning and reproduction, sexually transmitted diseases, and substance abuse. This information may not be shared with caseworkers, foster parents, or birth parents without the express consent of the minors with capacity to consent. Minors with capacity to consent should be encouraged to share information with adults responsible for them. Health care professionals should check with state legal authorities to clarify the rights of minors with capacity to consent in those states.
- Agency personnel and foster parents may, in general, have access to HIV-related information about children or adolescents in foster care, including minors with the capacity to consent. However, HIV-related information may not be disclosed to others, including

birth parents, without written release from minors with the capacity to consent. Human immunodeficiency virus–related information for children lacking capacity to consent may be shared with birth parents or others with the consent of those persons authorized to consent on behalf of the children. Health care professionals should clarify these issues with legal authorities in their own states.

Do Birth Parents Have Access to Medical Information for Their Children in Foster Care?

Most birth parents may have access to medical information for their children or adolescents in foster care. Health care professionals are advised to contact agencies to clarify whether an individual birth parent may have access.

- For birth parents whose children or adolescents are in voluntary placement, health care professionals may, and should, share medical information with the birth parents. Exceptions to sharing information with birth parents exist in some states. Health care professionals are advised to check with state legal authorities about rules in their own states. The following are noted exceptions to information sharing with birth parents:
 - A major exception is for HIV-related information in the case of minors with the capacity to consent. This information may only be disclosed to birth parents with the written consent of the minor with capacity to consent.
 - For minors with the capacity to consent, information related to family planning, reproduction, sexually transmitted diseases, and substance abuse may not be shared with anyone without the consent of the minors. This includes birth parents, case-worker staff, and foster parents.
 - For children in involuntary placement for whom birth parents retain guardianship, health care professionals are advised to seek counsel from the foster care agencies about the sharing of medical information.

- Once children or adolescents are freed for adoption, health care professionals are not to share any information with birth parents.

Do Other Professionals, Such as Attorneys and Court-appointed Special Advocates, Have Access to Health Information for Children and Adolescents in Foster Care?

Attorneys and court-appointed special advocates only have access to confidential medical information for children or adolescents in foster care through

- Subpoena
- Written consent of those persons authorized to consent on behalf of the children or adolescents

Human immunodeficiency virus–related information may not be released to these individuals unless specifically requested in the subpoena or authorized in the consent.

Privileged mental health information (ie, that information shared between a therapist and client) cannot be released to anyone except by a judicial court order specifically requesting the information. Health care professionals should seek guidance from administrative, legal, or health care management personnel at the agencies.

In Cases in Which Children or Adolescents Are Referred to Other Health Care Professionals for Health-related Issues, How Much Information Should Be Shared With Those Individuals?

When children or adolescents are referred to other health care professionals, medical history and other information that is relevant and sufficient to the health care of these children should be provided. Situations in which information sharing becomes necessary for the purposes of diagnosis and treatment include referrals to medical subspecialists and mental health, developmental, and educational professionals performing evaluations. Health care professionals must weigh the right to privacy against sharing information to facilitate care for these children.

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Qualifications of Health Care Professionals

At least one member of the foster care agency's health care management team must be a pediatrician, family medicine physician, pediatric or family nurse practitioner, or registered nurse with pediatric experience. It is assumed that the health care professionals on the health care management team have the skills necessary to perform the tasks outlined in Chapter 5.

Other Health Care Professionals

The professionals listed in this chapter must have training or experience in all aspects of the foster care system, understand the impact of foster care on children and adolescents, be willing and able to work with foster care agencies, and provide required documentation and reports in a timely manner. They also should be familiar with the guidelines and parameters as set forth in this manual.

Primary Care Physician

A well-qualified primary care physician who agrees to be the medical home provider for children and adolescents in foster care will

- Be a board-certified pediatrician or family physician or a pediatric or family nurse practitioner.
- Be experienced in providing comprehensive primary care for infants, children, and adolescents.
- Have experience in the areas of child abuse, neglect, and sexual abuse.
- Have experience with developmental and behavioral issues of infants, children, and adolescents.

- Have experience in family dynamics and its effects on children and adolescents and the effect of foster care placement on children and families.
- Participate in continuing medical education focusing on the special needs of infants, children, and adolescents in foster care.
- Demonstrate training or expertise in the area of foster care.
- Work collaboratively and cooperatively with caseworkers and legal professionals on behalf of children and adolescents in foster care.

Developmental and Mental Health Care Professionals

A well-qualified developmental or mental health care professional for children and adolescents in foster care is responsible for performing the developmental or mental health evaluation. Such health care professionals include

- Board-certified physicians experienced in providing developmental and mental health care services including developmental and behavioral pediatricians, child neurologists, child and adolescent psychiatrists, and general psychiatrists with special expertise in the emotional problems of children and adolescents*
- Licensed clinical psychologists with special expertise in the area of emotional problems of children and adolescents*
- Nurse practitioners or certified advance practice nurses with certification in child and adolescent psychiatry*
- Certified social workers with special expertise in the area of emotional problems of children and adolescents*

**Any of these individuals may serve as the care coordinator for the developmental or mental health agency for a child or adolescent in foster care.*

Other members of the team may include

- Speech and language pathologists (master's level or above) with training or experience in child speech pathology
- Special education diagnosticians (master's level or above)

- Physical and occupational therapists with training or experience in the motor problems of children
- School psychologists (master's level or above)
- Certified family therapists
- Certified arts therapists (eg, art, music, dance)
- School social workers (master's level or above)

Health Care Professionals for the Evaluation of Physical and Sexual Abuse

A well-qualified health care professional for the assessment of physical and sexual abuse will

- Be a board-certified pediatrician or family physician or pediatric nurse practitioner trained and experienced in physical and sexual abuse.
- Be recognized by peers as skilled or an expert in the field.
- Function within a specialized clinic or center for child abuse assessment and evaluation or its equivalent.

Subspecialty Physicians

All subspecialty physicians must be board-certified and experienced in providing subspecialty care to children and adolescents. When possible and appropriate, subspecialty physicians should be board-certified in pediatrics.



Quality Assessment and Improvement

The goal of quality assessment and improvement programs is to facilitate the highest possible level of patient care delivery with effective use of available resources while maintaining appropriate levels of responsibility and accountability.

The process for quality assessment and improvement for foster care health care delivery does not differ from that used for the non-foster care population. What is different are the standards used to measure quality and methods for information retrieval and sharing as outlined in this manual. In addition to quality assessment and improvement in the primary care office, there is the additional layer of quality assessment and improvement that must occur at the level of the agency, where the health care management function resides.

Overview

It is understood that quality assessment and improvement programs must include the following components at the health care professional and health care management levels:

- *Process* for identifying issues for quality assessment and improvement and sources from which to obtain this information. These issues may be identified in a variety of ways, including surveys (eg, foster parents, caseworkers); focus groups; complaints; city, state, and federal regulations; identification of trends; unfavorable outcomes; communication failures; and performance appraisals.
- *Assessment* to determine compliance with standards or identify sources of problems so they can be addressed realistically. It is recommended that interdisciplinary teams be used where appropriate. Issues can be investigated prospectively, concurrently, or

retrospectively. Data then can be aggregated and analyzed to identify patterns or trends.

- *Action plans* should be appropriate and timely and developed and implemented to promote improvement. Action plans after assessment may include the development of new policies or procedures.
- *Follow-up* of action plans is needed to ensure ongoing improvement.
- *Reporting* of findings and recommendations with all personnel involved is recommended and should be documented as part of the permanent quality assessment and improvement record.

For Health Care Professionals

Many indicators for monitoring the quality of health care received by children and adolescents have been developed. These may serve as templates for the development of indicators for foster care health care delivery as universal indicators for children are created. Examples of indicators currently in use at the health care professional's office level are

- Education in Quality Improvement for Pediatric Practice (*eQIPP*), American Academy of Pediatrics
- Health Plan Employer Data and Information Set (HEDIS), National Committee for Quality Assurance
- Quality Assurance Reporting Requirements (QARR), New York State Department of Health

None of these indicators is comprehensive or sufficient for this group of children and adolescents. It is hoped that health care professionals who elect to provide services to children and adolescents in foster care will develop specific indicators for this population. While these indicators help to ensure that children and adolescents in foster care receive health care services as outlined in this manual, they are measures of the process of health care, rather than health outcomes. Outcomes that are important to measure in this population include

emergency department use, inpatient hospitalization stays, residential placements, and psychiatric admissions. In addition, outcomes specific to the foster care population include overall health, stability of foster care placements, length of stay in foster care, and achievement of permanency.

For Health Care Management

Quality improvement and assessment at the level of the health care management team should, at a minimum, involve the setting of goals on an annual or semiannual basis. These goals could include specific indicators such as the collection of aggregate data on the foster care population to ensure that the health admission process and periodic preventive health care occur in a timely fashion and meet the standards of care outlined in this manual. Referrals also could be monitored for timeliness. The components of the medical file for a subset of the population could be reviewed for completeness. Standards for education of caseworkers, health care professionals, and foster parents should be developed as a long-range goal. Essentially, each of the tasks of the health care management team should be viewed as an opportunity to assess and improve the quality of management functions and health care delivery to children and adolescents in foster care.



Health Care Financing for Children and Adolescents in Foster Care

Health care financing for children and adolescents in foster care should support child welfare goals of health, safety, and permanency for children and adolescents. The goals of health care financing include

- Ensuring children receive health care according to standards outlined by the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Child Welfare League of America (CWLA), so that all of their health conditions are addressed
- Reducing long-term adverse health effects of abuse and neglect
- Improving long-term physical, emotional, developmental, and dental health outcomes
- Improving communication and coordination among health care professionals, caregivers, and child welfare professionals by adequately funding health care management
- Ensuring that children and adolescents continue to receive necessary health care services even after they exit foster care, at least for some specified time period

Currently, health care for children and adolescents in foster care is financed out of existing funding streams through Medicaid and foster care. Unfortunately, the financing has not been developed with the above goals in mind and does not necessarily support the goals. This chapter addresses, in limited detail, the current funding situation as it is outlined in federal regulations. However, each state interprets federal regulations and develops its own funding strategies; refer to each state's or county's entity for a fuller understanding of

local practice. To facilitate the discussion of health care financing, useful vocabulary, barriers to timely insurance coverage, and Medicaid regulations and mandates are also covered in this chapter. Finally, recommendations are put forth for financing health care for children and adolescents in foster care to achieve the above goals.

Useful Vocabulary

A number of factors affect health care financing for children and adolescents in foster care, including the structure of foster care in a state, the type of agency caring for the child, the level of care in which the child is placed, and Medicaid eligibility at the time of placement or shortly thereafter.

Some states have state-mandated and state-administered foster care, while others have state-mandated and county-administered foster care. In the latter, more decentralized model, child welfare practices may differ more widely among counties in the same state.

The type of agency caring for the child is either direct or indirect. *Direct care* is foster care provided by public (ie, government) entities, which may be state or county. *Indirect care* is foster care provided by private agencies, which may be nonprofit or for-profit; these agencies operate under contract or a memorandum of understanding with the state or local government entity. Agencies providing indirect foster care services may pay for health care out of a medical per diem the agency receives from the state, by enrolling children in Medicaid, or some mixture of both. When agencies receive a medical per diem, they are expected to pay out of pocket for at least some health care services. Some agencies choose to offer certain health care services on-site to offset a portion of the costs. Money not expended on health care services is available to the agency for other purposes for the current fiscal year, but may result in a reduction in the future per diem rate.

The term *level of care* indicates the placement setting in which a child resides and includes group homes, residential treatment facilities, and foster family homes. In some states, residential treatment facilities or group homes may be required to provide some or all health care services on-site. Again, health care may be funded through Medicaid or a medical per diem rate paid to the agency.

Medicaid

Medicaid is a federally mandated entitlement program authorized by Title XIX of the Social Security Act; Medicaid expenditures accounted for 10% of all federal child welfare money in fiscal year 2000. While federally mandated, states have flexibility in setting eligibility requirements, benefits, and reimbursements paid to providers. The federal government has set minimum criteria for Medicaid eligibility. Children younger than 6 years are presumed eligible if their families have an income less than 133% of the federal poverty level (\$19,977 for a family of 3 in 2002), while older children are eligible if their family income is less than 100% of the federal poverty level (\$15,020 for a family of 3 in 2002). Most states have liberalized these eligibility criteria. At admission to foster care, about 57% of children are eligible for Medicaid because their families were receiving cash assistance or were eligible under their state's welfare laws as they applied in 1996. Birth parents' income is counted only for the first month in foster care, so almost all children become eligible after the first month in foster care. States also have the option under federal law to extend Medicaid eligibility to targeted populations (eg, children in foster care) and make them immediately eligible at the time of placement.

Medicaid can be billed retroactively for 90 days, so even if a child only becomes eligible after the first month of placement, any health care services rendered in that first month should be reimbursed. The federal-state match also varies from state to state, with the federal share ranging from 50% to 83%.

Children may not have health coverage immediately upon entry to foster care for a variety of reasons, including

- Precipitous entry to foster care
- Lack of presumptive Medicaid eligibility at entry to foster care
- Delays in disenrollment from a prior health insurance plan, which delays enrollment in Medicaid
- Delays in issuance of a Medicaid card

Other barriers to health care related to insurance issues include the lack of portability of Medicaid managed care (MMC) across different foster care placements, loss of Medicaid cards when children change placements, lack of health care professionals who accept Medicaid fee-for-service (FFS) reimbursement, and restrictions imposed on certain health care services, particularly mental health visits, by MMC.

Medicaid Fee-for-service Versus Medicaid Managed Care

No discussion of health care financing for children and adolescents in foster care would be complete without focusing on the relative benefits of Medicaid FFS and MMC. In general, children in direct care who are Medicaid eligible are issued a Medicaid number, although the card may not be issued for days or even months after placement. The federal government allows most Medicaid beneficiaries to be enrolled in MMC, although waivers still are required for children with special health care needs or those in foster care. By 1999, 18 states required that children in foster care be enrolled in MMC, and 30 others allowed, but did not require, enrollment in MMC.

The disadvantages of Medicaid FFS are those of Medicaid in general. Because Medicaid reimbursement often is lower than that of other insurance plans and insufficient to cover the costs health care professionals incur in seeing children with special health care needs, access to health care services often is more limited. Medicaid FFS allows for

liberal access to mental health care services, which is considered an advantage for this population, although reimbursement limitations again may create access issues. Generally, reimbursement for dental services is well below parity, meaning access to dental care is extremely limited. Access issues are even more significant in rural areas where the numbers and types of health care professionals accepting Medicaid FFS are restricted.

The advantages of MMC are felt to be the improved access to primary health care, emphasis on preventive health care services, and improved data collection. Health care professionals generally are more appropriately reimbursed for their services under MMC, which should ameliorate some access barriers. However, there are ongoing concerns that access to some types of health care, especially mental health care services, is more restricted and may further increase the morbidity of this medically complex and needy population. The attractiveness of MMC for states resides in the potential for cost savings and access to more accurate aggregate health data about children and adolescents in foster care. Currently, most states consider children with special health care needs to be “averaged into” the overall MMC population when rates are set. This may work well for an MMC organization covering a broad spectrum of the pediatric population, of which foster care and other children with special needs constitute only a small part. Medicaid managed care rates are incompatible with costs when such an organization serves a larger proportion of children in foster care or with special health care needs.

Neither Medicaid FFS nor MMC allow agencies the freedom to fund more creative and possibly more effective methods of health care service delivery. This is of particular concern in the arena of mental health because even very young children may have significant emotional and behavioral issues that are not easily treated using traditional mental health models. Innovative approaches such as mentoring for foster or birth parents, peer support groups for children

and adolescents in foster care, therapeutic or mentored visitation, and contextual mental health assessment and services currently are only fundable through grant support. Therapy for substance addiction also is poorly funded, especially if children or adolescents require extended inpatient therapy services. Child psychiatry services are extremely difficult to access for this population. While this is partly attributed to the shortage of child psychiatrists in general, inadequate reimbursement poses another major barrier. Thus, many children in foster care are on psychotropic medication without benefit of psychiatric expertise.

Early and Periodic Screening, Diagnosis, and Treatment and Foster Care

States, local government, and MMC organizations are required to fulfill federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements for all children covered by Medicaid or MMC and all Medicaid-eligible children. Early and Periodic Screening, Diagnosis, and Treatment is a federally mandated comprehensive package of preventive services, tests, regular checkups, and mandated follow-ups for children younger than 21 years. This means that Medicaid has to cover the treatment and follow-up of any health care condition (eg, physical, emotional, developmental, behavioral) identified by a health care professional during a health visit. This is true even if the services are not routinely covered by an individual state's Medicaid benefit package. Compelling a state entity to cover such identified health conditions when they are not part of the benefit package may require diligent advocacy by foster parents, birth parents, health professionals, caseworkers, attorneys, health care managers, or other interested parties.

Studies in California and Washington have indicated that while children in foster care expend more health care dollars than other children, they still have multiple unmet health care needs. Data show that children in foster care use inpatient and outpatient

mental health care services at about 20 times the rate of other children who are poor in these states, although this higher rate of use still may underestimate the actual need. Children undergoing thorough evaluations at entry to care routinely have been found to have higher rates of chronic medical illness, developmental issues, and mental health conditions than are reported by caregivers or caseworkers prior to the evaluation. Such evaluations uncovered unrecognized and unmet physical, emotional, and developmental conditions up to 3 times more often than suspected prior to evaluation. Ideally, under federal EPSDT guidelines, there should be no unmet health care needs because all identified health conditions are eligible for services.

Financing Health Care Management

Health care management is fundamental to achieving good health outcomes for children and adolescents in foster care. Unfortunately, except for agencies that receive a medical per diem to coordinate and manage the health of children and adolescents in their care and custody, there currently is no mechanism for funding health care management. Health care management financing has to allow for flexibility in the delivery of health care services, provide incentives for enhanced communication among multidisciplinary professionals, and support the integration of health information and permanency planning. A number of different health care management models already exist, although all share the commonalities of using health care professionals responsible to foster care agencies to manage health care. Some models combine the health care delivery and management functions in a specialized primary care office or multidisciplinary health team devoted to the care of children and adolescents in foster care. Others use public health nurses working closely with foster care caseworkers. Another approach involves the use of health passports with centralized data collection to monitor health care at a population level. Financing has to allow for different strategies and models,

while promoting the goals of health care management as described in Chapter 5.

Principles of Health Care Financing

Health care financing for children and adolescents in foster care has to address the broad spectrum of health conditions, including unmet health needs, of this population in a planned, comprehensive manner. Federal EPSDT regulations mandate that any identified health condition must be treated. Funding for mental health and developmental assessments and services is particularly crucial in a population in which so many social and environmental factors may erode a child's emotional well-being or developmental competencies. The following principles are considered fundamental:

- Health insurance for children and adolescents in foster care has to have an extensive benefits package (*see* “Comprehensive Benefits Package” on page 122) to cover the wide array of services needed to ensure optimal physical, emotional, developmental, and dental health, as outlined in this manual and recommended by the AAP, AACAP, and CWLA.
- Adequate financing is essential to ensuring timely access to appropriate health care services. Children and adolescents in foster care should receive health care through a medical home (*see* Chapter 2), with health care professionals familiar with foster care, its mandates, and regulations and their effect on children and families. Health care professionals must be reimbursed for the more complex and lengthy visits that are typical of the foster care population. Mechanisms to recruit, train, and reimburse “preferred” health care professionals for children and adolescents in foster care should be part of financing considerations. Reimbursement rates should correlate with the expertise and experience of individual health care professionals in caring for this group of children. Foster care agencies should maintain a list of health care professionals within a reasonable distance of most foster care residences in their counties.

- Financing must cover the cost of the health care management necessary to ensure that this medically complex population receives appropriate and timely health care services. Health care management is not the same as case management by insurance providers; the latter is a separate function. Health care management is a responsibility of the foster care agency, but the functions have to be performed by health care professionals, regardless of the type or level of foster care placement. Funding streams in addition to Medicaid or medical per diem need to be established to pay for this function. Money must cover the complete array of health care management functions outlined in Chapter 5 of this manual.
- While health care management is focused on individual children, financing should provide a structure within which accountability across the foster care population occurs, including
 - Tracking compliance with health care standards
 - Ensuring the quality of health care services through rigorous monitoring and assessment
 - Ensuring frequent communication among health, child welfare, and health management systems about health care issues, changes in health benefits, health care access, quality of care, confidentiality, and continuity
 - Promoting fiscal management and cost-efficient care delivery
 - Ensuring confidentiality issues are addressed appropriately
- Financing should include funds for developing family-based approaches to mental health and developmental services. Such services could include, among others,
 - Therapeutic or mentored visitation models for children and birth parents
 - Contextual assessments that occur in the child’s environments rather than at a mental health agency
 - Foster or birth parent mentoring to improve the skills of parents in managing the behaviors of distressed children

- Wraparound services that address the complex educational, developmental, and emotional needs of families and children
- Insurance portability is extremely important for this mobile population. Insurance coverage has to begin immediately with placement and continue for the duration of a child's stay in foster care, regardless of changes in placement, level of placement, type of agency, or moves across county lines.
- There needs to be universal presumptive eligibility at entry to foster care. Children in kinship care need to be treated the same as children in traditional foster care with respect to health care financing. Exceptions may be made for children in kinship care with relatives whose income is more than 200% of the federal poverty level and who have another source of health insurance for children in their care and custody.
- Insurance coverage should extend automatically beyond foster care for 12 months. Adolescents leaving foster care should retain presumptive Medicaid eligibility for at least 12 months or until age 21 years, whichever is longer. All states should come into compliance with the Chafee Foster Care Independence Act concerning Medicaid eligibility for adolescents leaving foster care.

Comprehensive Benefits Package

Health care insurance for children and adolescents in foster care has to cover

- Comprehensive admission series as outlined in Chapter 2
- Enhanced well-child care schedule as described in Chapter 2
- Extra visits that occur related to foster care issues
- Discharge health planning
- Child abuse and neglect issues
- A wide array of mental health care services including comprehensive mental health evaluations at admission, ongoing indicated services or periodic reassessments of needs, and drug and alcohol evaluation and rehabilitation services

- Funding for other mental health strategies as outlined on pages 117 and 118
- A full developmental or educational evaluation, unless such an evaluation is available through other systems already in place (eg, early intervention programs), with ongoing indicated developmental services or periodic reassessments
- Emergency health services
- Respite services
- Indicated home health care services
- Medical equipment and supplies, including orthotics and prosthetics
- Inpatient hospital and mental health care services
- Medical transportation costs
- Laboratory costs
- Medications
- Optometry and corrective lenses
- Care for acute and chronic illnesses
- Dental evaluation with periodic reassessments and all indicated treatment, including orthodontia

Summary

Health care financing for children and adolescents in foster care should be designed to improve the overall physical, emotional, developmental, and behavioral health of children in foster care. In doing so, it should support the child welfare goals of health, safety, and permanency for children and adolescents. Because health care management is fundamental to integrating health care and child welfare planning, funding for this function is vital. In addition, health insurance for children and adolescents entering foster care should be immediate, universal, portable, and ongoing during the stay in foster care. It should support the principles outlined in this chapter, including providing a comprehensive benefits package, promoting the identification of a medical home for each and every child

and adolescent, and supporting the development of mental health strategies that address the special needs of this population. Lastly, health insurance should remain intact for at least 12 months after leaving care, to ensure that health conditions continue to be addressed beyond foster care.

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Internet Resources

Centers for Medicare and Medicaid Services: www.cms.hhs.gov



American Academy of Pediatrics Policy Statement,
“Health Care of Young Children in Foster Care,”
by the American Academy of Pediatrics Committee
on Early Childhood, Adoption, and Dependent Care
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AMERICAN ACADEMY OF PEDIATRICS

Committee on Early Childhood, Adoption, and Dependent Care

Health Care of Young Children in Foster Care

ABSTRACT. Greater numbers of infants and young children with increasingly complicated and serious physical, mental health, and developmental problems are being placed in foster care. All children in foster care need to receive initial health screenings and comprehensive assessments of their medical, mental, dental health, and developmental status. Results of these assessments must be included in the court-approved social services plan and should be linked to the provision of individualized comprehensive care that is continuous and part of a medical home. Pediatricians have an important role in all aspects of the foster care system.

ABBREVIATIONS. HIV, human immunodeficiency virus; CWLA, Child Welfare League of America; AAP, American Academy of Pediatrics.

BACKGROUND

The foster care system in America has evolved as a means of providing protection and shelter for children who require out-of-home placement.¹ Although it is designed to be a temporary service with the goal of returning children home or arranging for suitable adoptive homes, children are often in foster care for several years. In recent years, child welfare agencies have been directing greater efforts toward supporting families in crisis to prevent foster care placements, whenever feasible, through preventive service programs and to reunify families as soon as possible when placements cannot be avoided. Increasingly, extended family members are being recruited and assisted in providing kinship care for children when their birth parents cannot care for them. However, during the past decade, the number of children in foster care has doubled despite landmark federal legislation designed to expedite permanency planning for children in state custody.² Approximately 500 000 children are in foster care on any given day, an increase of 65% in the past 10 years.^{3,4} Between 1986 and 1991, the number of children younger than 5 years placed in foster care increased by 110% in large urban areas, with a larger proportion of infants

than in previous years. Infants and young children are the fastest growing population in need of foster care. Most of these children are placed in foster care because of abuse or neglect occurring within the context of parental substance abuse, extreme poverty, mental illness, homelessness, or human immunodeficiency virus (HIV) infection.⁵ As a result, a disproportionate number of children placed in foster care come from the segment of the population with the fewest psychosocial and financial resources and from families that have few personal and extended family sources of support.⁶

Recent brain research has shown that infancy and early childhood are critical periods during which the foundations for trust, self-esteem, conscience, empathy, problem solving, focused learning, and impulse control are laid down.^{7–15} Because multiple factors (eg, an adverse prenatal environment, parental depression or stress, drug exposure, malnutrition, neglect, abuse, or physical or emotional trauma) can negatively impact a child's subsequent development, it is essential that all children, but especially young children, are able to live in a nurturing, supportive, and stimulating environment.¹⁶

It is not surprising that children entering foster care are often in poor health. Compared with children from the same socioeconomic background, they have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and poor school achievement.^{6,17–29} Moreover, the health care these children receive while in placement is often compromised by insufficient funding, poor planning, lack of access, prolonged waits for community-based medical and mental health services, and lack of coordination of services as well as poor communication among health and child welfare professionals.^{3,30–33}

Despite the existence of recognized standards developed by the Child Welfare League of America (CWLA) in consultation with the American Academy of Pediatrics (AAP),³⁴ many child welfare agencies lack specific policies for children's physical and mental health services.³⁵ Recently, the AAP District II Committee on Early Childhood, Adoption, and Dependent Care Task Force on Health Care for Children completed a comprehensive resource manual that outlines areas of health concerns and sets forth guidelines for evaluating foster children's physical, developmental, mental health, and educational needs.³⁶ Although a broad range of supportive and therapeutic services is needed, most children do not undergo a comprehensive developmental or psychological assessment at any time during their placement. State Medicaid systems, which provide funding for the health care of nearly all children in foster care, rarely cover all of the services these children require.^{36–38}

It has been suggested that a variety of factors act as true barriers to care for these children. Information about health care services children have received and their health status before placement is often hard to obtain. In part, this is because children have had erratic contact with a number of health care providers before placement. In addition, social workers are not always able to review a child's health history in detail with birth parents at the time of placement. Foster care parents often have been given limited training in health care issues or in accessing the health care system. Social workers often lack information about the type of health care services that children in foster care receive and are, therefore, unable to effectively oversee the amount or quality of care delivered.³³ Increasingly complicated physical and mental health conditions in children in foster care make taking care of these children difficult, even for the committed physician.

A number of states are mandating that foster children shift from fee-for-service Medicaid to Medicaid managed care. Agencies must now consider arranging or purchasing comprehensive services within the 1996 managed health care model.³⁹ Concerns exist about rationing of services, especially within the mental health area. General principles exist for developing and implementing a statewide health care system for children in foster care, irrespective of the model.⁴⁰ When children are placed in foster homes outside the original jurisdiction or in another state, coordination of health care by the foster care agency becomes even more difficult.

Pediatricians can play a critically important role in helping child welfare agencies, foster families, and birth families minimize the trauma of placement separation and improve the child's health and development during the period of foster care. Providing health care to these children requires considerably more time than it does for the average pediatric patient. Physicians must be prepared to provide necessary care even when little or no specific information about the child is available at the time of the visit. The pediatrician should attempt to identify physical, psychosocial, and developmental problems and assist social workers and foster parents in determining the types of additional evaluation, care, and community services the child requires.^{3,41}

This statement provides specific suggestions for delivery of health services to young children in foster care. More detailed recommendations regarding developmental issues for young children in foster care have recently been published by the AAP.⁴²

STANDARDS FOR HEALTH CARE SERVICES

In 1988, the CWLA, in consultation with the AAP, developed *Standards for Health Care Services for Children in Out-of-Home Care*.³⁴ This document still serves as a comprehensive guideline for developing and organizing physical and mental health services for child welfare organizations. Child welfare agencies should be encouraged to adhere to these standards. *Fostering Health: Health Care for Children in Foster Care*, published in 2001 by District II of the AAP, details practice parameters for primary health care, developmental and mental health care, child abuse and neglect, and health care management.³⁶ This manual is a useful reference for medical, developmental, and mental health practitioners as well as child welfare professionals. Pediatricians should become familiar with these standards and assist child welfare administrators, caseworkers, and foster parents in implementing them.

Because children in foster care have a high prevalence of chronic and complex illnesses, assessing each child's unique needs is critical. Establishing continuity of care and ensuring a comprehensive and coordinated treatment approach by all professionals involved in their care should be one of the highest priorities for child welfare agencies. Diverse characteristics of child welfare agencies, wide geographic distribution of foster homes in some states, lack of comprehensive funding for children's physical and mental health care services, and inadequate physician compensation for these services contribute to the difficulty of providing an organized approach to the care of these children. To avoid fragmentation of care, a variety of health care delivery models can be developed for this population, including: a) agency-based care, in which children are brought into the agency for health care; b) specialized foster care clinics, in which a medical home is established for the child; and c) community-based care, in which a practitioner provides health care through a private office, health maintenance organization, neighborhood health center, or general academic pediatric clinic. In all models, health care coordination remains the responsibility of the foster care agency.

Regardless of the model developed in a locale, it should adhere to certain principles. Whether services are delivered by a single team of professionals under one roof⁴³ or as part of a planned program of care using many community resources,²¹ all professionals involved in the care of each child should communicate effectively with one another. Furthermore, compassionate assistance, education, and training for foster and birth parents should be included as an integral part of the overall program of services provided to children and their families during and after placement.

Pediatricians should be involved in the planning and development of systems of care for children in foster care. In addition to their role as primary health care providers, pediatricians may be contracted by child welfare agencies to serve as regional and statewide medical consultants and to develop and implement policies and programs that will improve the effectiveness and comprehensiveness of services for children in foster care.⁴⁴ Pediatrician participation in the Committee on Early Childhood, Adoption, and Dependent Care of the local AAP chapter is also important.

THE COMPONENTS OF HEALTH CARE SERVICES

Health care services may be divided into 4 components: initial health screening, comprehensive medical and dental assessment, developmental and mental health evaluation, and ongoing primary care and monitoring of health status.

Initial Health Screening

Every child entering foster care should have a health screening evaluation before or shortly after placement. The purpose of this examination is to identify any immediate medical, urgent mental health, or dental needs the child may have and any additional health conditions of which the foster parents and caseworker should be aware. Careful measurement of height, weight, and head circumference may reveal growth delays or reflect poor nutritional or general health status. Because many children entering foster care have been victims of physical or sexual abuse, all body surfaces should be unclothed at some point during the physical examination, and any signs of recent or old trauma, bruises, scars, deformities, or limitations in the function of body parts or organ systems should be noted and documented photographically. If there is a history of physical abuse before placement or if signs of recent physical trauma are present, appropriate imaging studies to screen for recent or healing fractures should be considered. Genital and anal examination of both sexes should be conducted, and laboratory tests should be performed for HIV and other sexually transmitted diseases when indicated clinically or by history.⁴⁵ Other infections and communicable diseases should be noted and treated promptly. The status of any known chronic illnesses should be determined to ensure that appropriate medications and treatments are available. The physician should discuss specific care instructions directly with the foster parents and caseworker and should not rely on an intermediary.

Comprehensive Health Assessment

Within 1 month of the child's placement, a comprehensive health assessment should be performed by a pediatrician who is knowledgeable about, and

interested in, the treatment of children in foster care and who can provide a medical home and arrange for the provision of regular, ongoing primary care services. Time permitting, it may be possible to do the screening and comprehensive assessments simultaneously. Child welfare agencies should make all pertinent past medical, social, and family information available to assist the physician performing the evaluation. The child's caseworker and foster parents should be present for the initial visit. Whenever possible for this and subsequent visits, information should be obtained from the birth parents, and they should be kept informed about the health status of their child. When appropriate and as a part of the care plan of the child welfare agency, birth parents should be encouraged to be present at health care visits and to participate in health care decisions. The historical review should include the circumstances that led to placement, the child's adjustment to separation from the birth family, adaptation to the foster home, developmental or school progress, and the agency's plans for permanency (ie, most commonly, return to parent or relative, adoption, or independent living). The physical examination should focus on the presence of any acute or chronic medical problems that may require additional evaluation or referral. Screening tests should be performed according to the *AAP Recommendations for Preventive Pediatric Health Care*.⁴⁶ Because many young children entering foster care come from settings in which substance abuse and sexual promiscuity are common, they should be considered to be at high risk for HIV infection, hepatitis, and other sexually transmitted infections. Laboratory tests for these conditions should be performed when appropriate.^{45,47-49}

Children entering foster care are likely to be incompletely immunized,¹⁸ and determining the types and number of immunizations that a particular child has received in the past may be difficult. By communicating directly with previous medical providers or reviewing previous medical records (eg, from schools or immunization registries), it is often possible to reconstruct the child's immunization history. For some children, despite a thorough effort, little or no immunization information will be available. These children should be considered susceptible and immunized according to AAP guidelines.⁵⁰

Developmental and Mental Health Evaluation

At each health visit, the pediatrician should attempt to assess the child's developmental, educational, and emotional status. These assessments may be based on structured interviews with the foster parents and caseworker, the results of standardized tests of development, or a review of the child's school progress. All children with identified problems should be promptly evaluated and treated as clinically indicated. When available, local consultants and community-based

intervention programs should be called on to assist in diagnosing and treating children with developmental and educational problems. Pediatricians may also assist social workers and foster parents by referring eligible children to various federal and state entitlement programs in their community (eg, Supplemental Nutrition Program for Women, Infants, and Children [WIC] and Head Start, Birth-to-Three,⁵¹ special education,⁵² early intervention,^{51,53} and Title V programs).

In some communities, child welfare agencies may be able to access or establish multidisciplinary teams to routinely evaluate children entering foster care. By their very nature, multidisciplinary teams provide a comprehensive and coordinated approach to assessment and are often an efficient and cost-effective means of accomplishing this task. Several successful community-based program models using this approach have been described.^{3,21,25,41,54}

Regardless of how the comprehensive assessment is performed, the results and recommendations should be incorporated into the child's court-approved social service case plan.⁵⁵ To ensure that the multiple needs of children in foster care are addressed by those involved in the court process, 1 state judicial commission has developed an excellent guide for judges, advocates, and child welfare professionals to refer to, with a checklist of 10 basic questions that should be answered to ensure that standards of health care are met.⁵⁵ The caseworker and pediatrician should then help the foster parents arrange for all of the services recommended for the child.

Providing Primary Care and Monitoring of Children's Health Status While in Placement

Placement in foster care is a stressful experience for most children. Often, problems arise during the course of placement that were not apparent at the outset. For example, a child's adjustment to separation from his or her family and adaptation to the foster home may be characterized by distinct behavioral changes over time.⁵⁶ Similarly, significant emotional distress may occur after visits with birth family members or at times of transition, such as a change in placement or return to birth parents.⁵⁷ Therefore, all children in foster care should have a medical home in which they receive ongoing primary care and periodic reassessments of their health, development, and emotional status to determine any changes in their status or the need for additional services and interventions. Ideally, at a minimum such reassessments should occur monthly for the first 6 months of age, every 2 months for ages 6 to 12 months, every 3 months for ages 1 to 2 years, every 6 months for ages 2 through adolescence, and at times of significant changes in placement (foster home transfers,

approaching reunification). These periodicity recommendations, although not backed by evidence-based data, are considered by this committee to be the minimal number of preventive health care encounters required to closely monitor these children. Depending on the stability of the placement and changes in the child's status, additional visits may be indicated. Any child prescribed psychotropic medication must be closely monitored by the prescribing physician for potential adverse effects. The social worker should maintain contact with the provider and receive periodic updates on the child's progress. When changes in foster placement are planned or when decisions regarding permanency planning are anticipated, pediatricians can help child welfare professionals evaluate these decisions in light of the child's age and developmental level. Pediatricians can also work with the child welfare agency and the court to determine what is truly in the child's best interest.

TRANSFER OF MEDICAL INFORMATION

Up to one quarter of children placed in foster care experience 3 or more changes in foster homes. Furthermore, up to 35% of children reenter the foster care system after being returned to their families. Placement changes are usually accompanied by changes in physicians.⁵⁸ As a result, available health information about these children is often incomplete and spread across many different sites. To enhance continuity of care, several states have developed an abbreviated health record often called a medical passport.⁴⁴ A medical passport held by the foster parent has the potential to play a valuable role in the overall health care of children in foster care for some time to come. This form is retained by the child's custodian and is designed to facilitate the transfer of essential information among physical and mental health professionals. It provides a brief listing of the child's medical problems, allergies, chronic medications, and immunization data as well as basic social service and family history. Foster parents are instructed to keep this document for the child and bring it to all health visits. As the child's condition changes, health care providers should update the information on the form. If the child changes foster homes or returns to his or her birth family, the medical passport should also be transferred to the child's new caregiver. Computerized health information systems are also being developed in several states to make specific health information about children in foster care more readily accessible to practitioners and child welfare agencies. Computerized medical records for these children should be accorded the same confidentiality as written records.

THE IMPACT OF FOSTER CARE PLACEMENT ON CHILDREN

Society has always been reluctant to involuntarily remove children from their parents. Certainly, even brief separation from parental care is an unfortunate and usually traumatic event for children.^{41,59,60} Despite legal mandates to expeditiously formulate a permanency plan, many children may remain in foster care interminably while the child welfare and legal systems deliberate their fate. However, concerns about time should be balanced against other evidence that suggests that foster care placement may be a positive and therapeutic intervention for some children.⁶¹ The importance of a competent, caring, nurturing foster parent in supporting and advocating for a child's health and well being cannot be stressed enough. Significant improvements in a child's health status²⁰ and development, intelligence, school attendance, and academic achievement have been noted consequent to foster care placement.⁴² Thus, for children who have suffered severe neglect and abuse or whose families cannot adequately care for them, placement in foster care can be an important opportunity to receive intervention and rehabilitation and should not be considered only as an option of last resort.

RECOMMENDATIONS

1. Pediatricians should participate in the care of children in foster care as primary care physicians and as consultants to child welfare agencies. Child welfare agencies, general pediatricians, and pediatric subspecialists should work together to implement standards for health care of children in foster care developed by District II of the AAP.³⁶
2. All children entering foster care should have an initial physical examination before or soon after placement. This examination should focus on identifying acute and chronic conditions requiring expedient treatment.
3. All children in foster care should receive comprehensive physical and mental health and developmental evaluations within 1 month of placement.
4. Individual court-approved social service case plans should include the results of physical and mental health and developmental assessments and incorporate the recommendations of health professionals.
5. Pediatricians and child welfare agencies should work together to ensure that children in foster care receive the full range of preventive and therapeutic services needed and participate in all federal and state entitlement programs for which they are eligible.
6. Although in placement, the child in foster care requires physical, developmental, and mental health status monitoring more frequently than children living in stable homes with competent parents.

7. Child welfare agencies and health care providers should develop and implement systems to ensure the efficient transfer of physical and mental health information among professionals who treat children in foster care.

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American Academy of Pediatrics Policy Statement,
“Developmental Issues for Young Children in Foster
Care,” by the American Academy of Pediatrics Committee
on Early Childhood, Adoption, and Dependent Care
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AMERICAN ACADEMY OF PEDIATRICS

Committee on Early Childhood, Adoption, and Dependent Care

Developmental Issues for Young Children in Foster Care

ABSTRACT. Greater numbers of young children with complicated, serious physical health, mental health, or developmental problems are entering foster care during the early years when brain growth is most active. Every effort should be made to make foster care a positive experience and a healing process for the child. Threats to a child's development from abuse and neglect should be understood by all participants in the child welfare system. Pediatricians have an important role in assessing the child's needs, providing comprehensive services, and advocating on the child's behalf.

The developmental issues important for young children in foster care are reviewed, including: 1) the implications and consequences of abuse, neglect, and placement in foster care on early brain development; 2) the importance and challenges of establishing a child's attachment to caregivers; 3) the importance of considering a child's changing sense of time in all aspects of the foster care experience; and 4) the child's response to stress. Additional topics addressed relate to parental roles and kinship care, parent-child contact, permanency decision-making, and the components of comprehensive assessment and treatment of a child's development and mental health needs.

More than 500 000 children are in foster care in the United States.^{1,2} Most of these children have been the victims of repeated abuse and prolonged neglect and have not experienced a nurturing, stable environment during the early years of life. Such experiences are critical in the short- and long-term development of a child's brain and the ability to subsequently participate fully in society.³⁻⁸ Children in foster care have disproportionately high rates of physical, developmental, and mental health problems^{1,9} and often have many unmet medical and mental health care needs.¹⁰ Pediatricians, as advocates for children and their families, have a special responsibility to evaluate and help address these needs.

Legal responsibility for establishing where foster children live and which adults have custody rests jointly with the child welfare and judiciary systems.

Decisions about assessment, care, and planning should be made with sufficient information about the particular strengths and challenges of each child. Pediatricians have an important role in helping to develop an accurate, comprehensive profile of the child. To create a useful assessment, it is imperative that complete health and developmental histories are available to the pediatrician at the time of these evaluations. Pediatricians and other professionals with expertise in child development should be proactive advisors to child protection workers and judges regarding the child's needs and best interests, particularly regarding issues of placement, permanency planning, and medical, developmental, and mental health treatment plans. For example, maintaining contact between children and their birth families is generally in the best interest of the child, and such efforts require adequate support services to improve the integrity of distressed families. However, when keeping a family together may not be in the best interest of the child, alternative placement should be based on social, medical, psychological, and developmental assessments of each child and the capabilities of the caregivers to meet those needs.

Health care systems, social services systems, and judicial systems are frequently overwhelmed by their responsibilities and caseloads. Pediatricians can serve as advocates to ensure each child's conditions and needs are evaluated and treated properly and to improve the overall operation of these systems. Availability and full utilization of resources ensure comprehensive assessment, planning, and provision of health care. Adequate knowledge about each child's development supports better placement, custody, and treatment decisions. Improved programs for all children enhance the therapeutic effects of government-sponsored protective services (eg, foster care, family maintenance).

The following issues should be considered when social agencies intervene and when physicians participate in caring for children in protective services.

EARLY BRAIN AND CHILD DEVELOPMENT

More children are entering foster care in the early years of life when brain growth and development are most active.¹¹⁻¹⁴ During the first 3 to 4 years of life, the anatomic brain structures that govern personality traits, learning processes, and coping with stress and emotions are established, strengthened, and made permanent.^{15,16} If unused, these structures atrophy.¹⁷ The nerve connections and neurotransmitter networks that are forming during these critical years are influenced by negative environmental conditions, including lack of stimulation, child abuse, or violence within the family.¹⁸ It is known that emotional and cognitive disruptions in the early lives of children have the potential to impair brain development.¹⁸

Paramount in the lives of these children is their need for continuity with their primary attachment figures and a sense of permanence that is enhanced when placement is stable.¹⁰ There are critical periods of interaction among physical, psychological, social, and environmental factors. Basic stimulation techniques and stable, predictable nurturance are necessary during these periods to enable optimal cognitive, language, and personal socialization skills. Because these children have suffered significant emotional stress during critical periods of early brain development and personality formation, the support they require is reparative as well as preventive. The pediatrician, with knowledge of the child's medical and family history, may assist the social service and judicial systems in determining the best setting to help the child feel safe and heal.

ATTACHMENT

To develop into a psychologically healthy human being, a child must have a relationship with an adult who is nurturing, protective, and fosters trust and security.¹⁹ Attachment refers to this relationship between 2 people and forms the basis for long-term relationships or bonds with other persons. Attachment is an active process—it can be secure or insecure, maladaptive or productive. Attachment to a primary caregiver is essential to the development of emotional security and social conscience.²⁰

Optimal child development occurs when a spectrum of needs are consistently met over an extended period. Successful parenting is based on a healthy, respectful, and long-lasting relationship with the child. This process of parenting, especially in the psychological rather than the biologic sense, leads a child to perceive a given adult as his or her “parent.” That perception is essential for the child's development of self-esteem and self-worth.²¹ A child develops attachments and recognizes as parents adults who provide “. . . day-to-day attention to his needs for physical care, nourishment, comfort, affection, and stimulation.”²¹ Abused and neglected children (in or out of foster care) are at great risk for not forming healthy attachments to anyone.^{9,10} Having at least 1 adult who is devoted to and loves a child unconditionally, who is prepared to accept and value that child for a long time, is key to helping a child overcome the stress and trauma of abuse and neglect.

The psychosocial context and the quality of the relationship from which a child is removed, as well as the quality of alternative care that is being offered during the separation, must be carefully evaluated. This information should be used to decide which placement is in the child's best interest. The longer a child and parent have had to form a strong attachment with each other (ie, the

older the child) the less crucial the physical proximity will be to maintain that relationship. Separation during the first year of life—especially during the first 6 months—if followed by good quality of care thereafter, may not have a deleterious effect on social or emotional functioning. Separations occurring between 6 months and about 3 years of age, especially if prompted by family discord and disruption, are more likely to result in subsequent emotional disturbances. This partly results from the typical anxiety a child this age has around strangers and the normal limitations of language abilities at this age. Children older than 3 or 4 years placed for the first time with a new family are more likely to be able to use language to help them cope with loss and adjust to change. These preschool-aged children are able to develop strong attachments and, depending on the circumstances from which they are removed, may benefit psychologically from the new setting.

The emotional consequences of multiple placements or disruptions are likely to be harmful at any age, and the premature return of a child to the biologic parents often results in return to foster care or ongoing emotional trauma to the child.²² Children with attachment disorders and an inability to trust and love often grow up to vent their rage and pain on society.¹⁹

CHILDREN'S SENSE OF TIME

Children are placed in foster care because of society's concern for their well-being. Any time spent by a child in temporary care should be therapeutic but may be harmful to the child's growth, development, and well-being. Interruptions in the continuity of a child's caregiver are often detrimental. Repeated moves from home to home compound the adverse consequences that stress and inadequate parenting have on the child's development and ability to cope. Adults cope with impermanence by building on an accrued sense of self-reliance and by anticipating and planning for a time of greater constancy. Children, however, especially when young, have limited life experience on which to establish their sense of self. In addition, their sense of time focuses exclusively on the present and precludes meaningful understanding of "temporary" versus "permanent" or anticipation of the future. For young children, periods of weeks or months are not comprehensible. Disruption in either place or with a caregiver for even 1 day may be stressful. The younger the child and the more extended the period of uncertainty or separation, the more detrimental it will be to the child's well-being.²¹

Any intervention that separates a child from the primary caregiver who provides psychological support should be cautiously considered and treated as a

matter of urgency and profound importance. Pediatricians should advocate that evaluation, planning, placement, and treatment decisions be made as quickly as possible, especially for very young children.

RESPONSE TO PSYCHOLOGICAL STRESS

The body's physiologic responses to stress are based on involuntary actions of the brain. Physical and mental abuse during the first few years of life tends to fix the brain in an acute stress response mode that makes the child respond in a hypervigilant, fearful manner.^{18,22} Research demonstrates chemical and electrical evidence for this type of brain response pattern.^{18,23} The age of the child dictates the developmental response and manifestations to stress. When an infant is under chronic stress, the response may be apathy, poor feeding, withdrawal, and failure to thrive. When the infant is under acute threat, the typical "fight" response to stress may change from crying (because crying did not elicit a response) to temper tantrums, aggressive behaviors, or inattention and withdrawal.²⁴ The child, rather than running away (the "flight" response), may learn to become psychologically disengaged, leading to detachment, apathy, and excessive daydreaming. Some abused and neglected children learn to react to alarm or stresses in their environment reflexively with immediate cessation of motor activity (freeze response). Older children who have been repeatedly traumatized often suffer from posttraumatic stress disorder and automatically freeze when they feel anxious, and therefore are considered oppositional or defiant by those who interact with them.

The same areas of the brain that are involved in the acute stress response also mediate motor behavior and such functions as state regulation and anxiety control.²³ Repeated experiencing of traumatic events can lead to dysregulation in these various functions resulting in behaviors such as motor hyperactivity, anxiety, mood swings, impulsiveness, and sleep problems.¹⁸

EFFECTS OF NEGLECT

An increasing number of young children are being placed in foster care because of parental neglect.¹ Neglect has very profound and long-lasting consequences on all aspects of child development—poor attachment formation, understimulation, development delay, poor physical development, and antisocial behavior.^{8,17,25–27} Being in an environment in which child-directed support and communication is limited makes it more difficult for a child to develop the brain connections that facilitate language and vocabulary development, and therefore may impair communication skills.²⁸ Recent findings in infant mental health

show how development can be facilitated, how treatment can enhance brain development and psychological health, and how prevention strategies can lessen the ill effects of neglect.²⁹

COMPREHENSIVE ASSESSMENT OF THE AT-RISK CHILD—BEFORE PLACEMENT

Knowledge of normal child development and family functioning helps identify children receiving insufficient and inappropriate care as well as children who are victims of, or at risk for, abuse or neglect. Comprehensive pediatric assessments can complement programs that prevent abuse and neglect, decrease the likelihood of placement in foster care, identify whether a child's current needs are being met, and allow placements to be customized to meet each child's needs.

COMPREHENSIVE ASSESSMENT OF CHILDREN IN FOSTER CARE—AFTER PLACEMENT

A pediatric assessment should be done within 30 days of placement.³⁰
This evaluation must be:

1. *Comprehensive*: Appropriate in breadth and depth, assessing physical, behavioral, emotional, cognitive, relational, and environmental domains.
2. *Integrative*: Address the effect any 1 domain of function has on another domain of function (eg, impact of motor deficits on speech).
3. *Developmental*: Age-appropriate using validated instruments that are sensitive to changes in development over time.
4. *Preventive*: Anticipatory, focusing on early identification and interventions.
5. *Longitudinal*: Based on data collected over time to determine problems, each child's abilities, and future course.
6. *Summative*: Able to synthesize and compile results for the purpose of prioritization.
7. *Culturally Sensitive*: Sensitive to different values, meanings, and perceptions of importance.
8. *Child-Sensitive*: Conducted in settings and in a manner that protects the child's comfort and that controls and limits the stress of the evaluation.
9. *Standardized*: Sensitive, specific, valid, and reliable.
10. *Child Welfare-Sensitive*: Consistent with norms, standards, and goals of child welfare.
11. *Parsimonious*: Compact, efficient, and able to be completed in a reasonable amount of time.

At a minimum, the following areas should be assessed:

- Gross motor skills
- Fine motor skills
- Cognition
- Speech and language function
- Self-help abilities
- Emotional well-being
- Coping skills
- Relationship to persons
- Adequacy of caregiver's parenting skills
- Behaviors

TREATMENT

The comprehensive assessment should lead to an individualized court-approved treatment plan and ongoing monitoring by a multidisciplinary team skilled in working with this population in the context of a medical home.³¹ In-home monitoring, placement with a relative (“kinship care”), or out-of-home placement should support each child’s psychological and developmental needs. Parents and foster parents must be well-informed about the importance of the environment in the development of normal brain function and the specifics needed for the child under care. Children can often be helped by providing predictability, nurturance, support, and cognitive or insight-oriented interventions to make them feel safe, comfortable, and loved. Specific mental health plans must be developed to meet the functional needs of each child.

Early interventions are key to minimizing the long-term and permanent effects of traumatic events on the child’s brain.^{14,17,32–36} After the first several years of a child’s life, patterns of interaction with the world are formed, both psychologically and in the brain structure, making it more difficult, though still possible, to improve a child’s physical, cognitive, and emotional abilities.¹⁷ Several studies have shown how favorable and stimulating environments for infants and young children can lessen the adverse effects of prior negative environments.²⁷ Pediatricians have an important role in recognizing problem situations in the home and for children already in foster care. Prompt referrals should be made for early intervention services to secure full developmental assessments and treatments under the Individuals With Disabilities Act.

PLACEMENT ISSUES

Courts with jurisdiction over families and children have been charged by Congress and the states to ensure that “reasonable efforts” are made to preserve and repair families or to place children in foster care when necessary. The courts also have the responsibility to make foster care a healing process. Given limited social, economical, educational, and health care resources, the judiciary has a responsibility to try to make needed resources available in the community and to decide whether application of available resources has been reasonable and appropriate. An array of supportive services should be available to assist families in child rearing and to offer alternative and therapeutic parenting (ie, foster care) when temporary removal of the child from the home is required.

The measure of *reasonable and appropriate* should always be what is in the best interests of the child. Lack of agreement exists about what constitutes such reasonable efforts. Principles of child development and expert consultation can provide guidance to assist in determining what is in the best interest of the child and whether these interests can be best met within the biologic family or another family. The lack of available resources to ensure a reasonable effort should not be used by the protective services agencies as an excuse to delay a permanent placement plan for a child.

PARENTAL ROLES AND KINSHIP CARE

The increasing number of children entering foster care, the insufficient number of suitable foster homes, and the increased interest by extended families to care for their kin have led social service agencies to place children with their extended families. Placement with a relative has psychological advantages for a child in terms of knowing his or her biologic roots and family identity. It may offer a better chance for stability and continuity of caregiving. However, little is known about the outcomes of kinship placement, and it should not be assumed to offer a superior home environment.³⁷ Supervision by social workers of relatives providing foster care is often less intense and family support services are less available than when a child is placed in nonkinship foster care. Placement with a relative may lead to a circuitous and unintended return of the child to his or her parents.

The report by the National Commission on Family Foster Care states: “The use of kinship care has expanded so rapidly that child welfare agencies are making policy, program, and practice decisions that lack uniformity and/or a substantive knowledge base. Kinship care provides an opportunity to affirm the value of families. But the assessment process and support should include unique family strengths and needs, cultural and ethnic identification, necessary

financial and service supports, continuity of care, and permanency goals.”³⁸ Studies suggest that a range of parenting arrangements can provide the feelings of permanency, security, and emotional constancy necessary for normal development.³⁹

VISITING (PARENT-CHILD CONTACT)

Children in out-of-home dependent care are usually accorded a schedule of visits with their parents. The intent is to maintain or improve the child-parent relationship, to give the social service agency an opportunity to observe and improve the parent-child interaction, and to monitor the parents’ progress. The visits are frequently brief encounters occurring on a weekly basis, in a neutral setting if possible, often under the supervision of a caseworker. For younger children, this type of visit is not conducive to optimal parent-child interaction and may minimally serve the parents’ needs for ongoing contact with the child or may even be harmful for the child. A young child’s trust, love, and identification are based on uninterrupted, day-to-day relationships. Weekly or other sporadic “visits” stretch the bounds of a young child’s sense of time and do not allow for a psychologically meaningful relationship with estranged biologic parents. For older children, such sporadic and brief visits may be sufficient to maintain a meaningful parent-child relationship.

For parent-child visits to be beneficial, they should be frequent and long enough to enhance the parent-child relationship and to effectively document the parent’s ongoing interest and involvement with the child. Sporadic visits are appropriate if an older child has established a strong attachment to the parent before entering foster care or if the visits are sufficient in frequency, length, and content to contribute to the child’s continuing normal development and enhanced parent-child relationship.

STABLE PLACEMENT VERSUS LEGAL CUSTODY VERSUS PERMANENCE

Children who have experienced abuse or neglect have a heightened need for permanency, security, and emotional constancy and are, therefore, at great risk because of the inconsistencies in their lives and the foster care system. Every effort should be made to rapidly establish a permanent placement for the child. Tangible continuity in relationships with family and friends is essential for a child’s healthy development. Stability in child care and the school environment is important. Multiple moves while in foster care (with the attendant disruption

and uncertainty) can be deleterious to the young child's brain growth, mental development, and psychological adjustment.

All children, regardless of their type of placement, must receive individual attention from their caregivers. Foster parents and extended family members can play a significant role when the child's mother or father cannot. Impersonal placement settings do not effectively support young children who have been abused and neglected. Bureaucratic proceedings, including conferring legal status, are usually of little or no consequence to children, whose needs are much more fundamental. Generally, assignment of custody should reinforce a child's perception of belonging and should not disrupt established psychological ties except when safety or emotional well-being are in jeopardy.

RECOMMENDATIONS

All placement, custody, and long-term planning decisions should be individualized for the child's best interest and should maximize the healing aspects of government-sponsored protective services. These decisions should be based in part on a comprehensive assessment and periodic reassessment of the child and family by professionals who are experts in pediatrics and child development (eg, pediatrician, psychiatrist, or psychologist).²² An ongoing relationship between the pediatrician and the child and family can provide valuable insights about a child's needs and the ability of a family to meet them. Pediatricians should actively participate in prevention services for at-risk families and placement, custody, and long-term planning decisions for children for whom they provide care, taking into account the following considerations.⁴⁰

The following important concepts should guide pediatricians' activities as they advocate for the child:

1. Biologic parenthood does not necessarily confer the desire or ability to care for a child adequately.
2. Supportive nurturing by primary caregivers is crucial to early brain growth and to the physical, emotional, and developmental needs of children.
3. Children need continuity, consistency, and predictability from their caregiver. Multiple placements are injurious.
4. Attachment, sense of time, and developmental level of the child are key factors in their adjustment to environmental and internal stresses.
5. Pediatricians can play a constructive role in the referral, assessment, and treatment of children who are at risk for being abused, neglected, or abandoned or who are involved in the protective services system.

6. Pediatricians need to encourage caregivers to:
 - give the child plenty of love and attention.
 - be consistent with love, stimulation, and discipline.
 - stimulate the child through exposure to developmentally appropriate holding, conversation, reading, music, and toys.
 - expose the child to opportunities to improve language via direct voice and face-to-face contact.
 - match the environment to the child's disposition.
7. Parents should be given reasonable assistance and opportunity to maintain their family, while the present and future best interests of the child should determine what is appropriate.
8. A child's attachment history and sense of time should guide the pace of decision-making.
9. Foster care placements should always maximize the healing aspects of foster care and be based on the needs of the child.
10. Foster care placement with relatives should be based on a careful assessment of the needs of the child and of the ability of the kinship care to meet those needs. As with all foster care placements, kinship care must be supported and supervised adequately.

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AMERICAN ACADEMY OF PEDIATRICS

Committee on Pediatric AIDS

Identification and Care of HIV-Exposed and HIV-Infected Infants, Children, and Adolescents in Foster Care

ABSTRACT. As a consequence of the expanding human immunodeficiency virus (HIV) epidemic and major advances in medical management of HIV-exposed and HIV-infected persons, revised recommendations are provided for HIV testing of infants, children, and adolescents in foster care. Updated recommendations also are provided for the care of HIV-exposed and HIV-infected persons who are in foster care.

ABBREVIATIONS. HIV, human immunodeficiency virus; AAP, American Academy of Pediatrics; PCR, polymerase chain reaction.

An estimated 500 000 children and adolescents in the United States are in foster care.¹ Entrance to the foster care system may occur as a consequence of parental substance abuse, neglect, physical abuse, sexual abuse, or loss of biologic parent(s) resulting from abandonment, incarceration, disability, or death. As many as 78% of children in foster care have a parent with a history of substance abuse, and as many as 94% of infants in foster care are born to women who abuse substances.² The number of women with human immunodeficiency virus (HIV) infection has increased substantially, and most of these women are of childbearing age. Approximately 7000 births occur annually in the United States to HIV-infected women, and most of these women have been infected through heterosexual contact or as a consequence of drug use.³ Seroprevalence of HIV infection in pregnancy nationwide is 1.7 per 1000 pregnant women, and in New York, where all newborns are tested for the HIV antibody, seroprevalence is 4 per 1000 pregnant women.⁴ An inner-city study found that newborns placed in foster care at the time of hospital discharge were 8 times more likely to have been born to HIV-infected women than were newborns discharged to the care of their mothers.⁵

In addition to the increased risk of perinatally acquired HIV infection for those in foster care, children and adolescents in foster care may have been sexually abused, placing them at risk for acquisition of HIV infection. Adolescents who use drugs or are sexually active are also at risk for acquisition of HIV infection, and adolescent risky behavior may precede placement in foster care or may occur while in foster care. Although advances in antiretroviral therapy for adults have helped decrease the projections of 80 000 to 150 000 children and adolescents orphaned in the United States by the death of their mother to acquired immunodeficiency syndrome by the year 2000,^{6,7} many HIV-infected women will still not survive to raise their offspring to adulthood, and their children may enter the foster care system as a consequence of maternal disability or death. Data from the Pediatric Spectrum of Disease project revealed that 45% of children born to HIV-infected women resided with a primary caregiver who was not the biological parent.⁸

Advances in the management of HIV infection include prenatal and postnatal administration of zidovudine to reduce the risk of infection of the infant, recommendations for initiation of *Pneumocystis carinii* pneumonia prophylaxis by 6 weeks of age for all infants born to HIV-infected women, variations in immunization recommendations for infected persons and infants at risk of infection, and recommendations for consideration of early and aggressive combination antiretroviral therapy for those who are infected.⁹⁻¹¹ The American Academy of Pediatrics (AAP) therefore issues recommendations in accordance with these recent advances to address the identification and care of HIV-exposed and HIV-infected infants, children, and adolescents in foster care.

HIV TESTING OF A CHILD IN FOSTER CARE WHO IS 1 YEAR OF AGE OR YOUNGER

The AAP, the American College of Obstetricians and Gynecologists, and the US Public Health Service have recommended that all pregnant women in the United States receive counseling about HIV infection and the benefits to the mother and her infant of knowing her serologic status and that all pregnant women should undergo routine testing for HIV.¹²⁻¹⁴ The Institute of Medicine recently recommended a nationwide policy of HIV testing during pregnancy (with right of refusal).⁴ In addition, if the mother's HIV status was not determined during pregnancy, the AAP recommends that, after birth of the infant, the pediatrician discuss with the mother the benefits to the infant of knowing the mother's serologic status and recommend testing at that time.¹²

The management of the HIV-exposed infant is complex and includes continuation of zidovudine prophylaxis during the first 6 weeks after birth, initiation of prophylaxis for *Pneumocystis carinii* pneumonia by 6 weeks of age in all infants born to HIV-infected women, monitoring of hematologic and immunologic parameters, specific laboratory testing to determine HIV infection status (DNA polymerase chain reaction [PCR] or viral culture), and variations in immunization recommendations.⁹ Advances in laboratory diagnosis (DNA PCR and viral culture for HIV) enable physicians to determine infant infection status by 28 days of age in as many as 96% of infants born to HIV-infected women.^{15,16} Published data suggest that RNA PCR may prove useful for early identification of infant infection status.^{17,18} Prompt identification of infected infants permits early initiation of aggressive antiretroviral therapy with the potential to prevent the rapid progression of illness seen in some HIV-infected infants.

Thus, to provide appropriate medical care for the infant, it is necessary that foster care agencies obtain information about HIV exposure status, if known, for infants placed in foster care. If the maternal serologic status is unknown, the HIV exposure status of infants in foster care, including infants placed in foster care at nursery discharge and infants placed in foster care who are 1 year of age or younger, should be determined by testing the infants for HIV antibody. When the authority to consent to medical care has been transferred from the biological parents to a foster care agency, and the HIV-exposure status of the infant is unknown, the agency should provide consent for HIV testing of the infant and have an established mechanism to facilitate testing and to allow exchange of confidential information with appropriate persons (eg, physician, nurse, caseworker coordinating care for the foster child, biological parents, and the foster parents). Occasionally, legal restrictions may prevent testing of the infant in foster care without maternal consent. In such cases, the physician may need to consult with the foster care agency and legal authorities. Efforts should be made to educate the biological mother, if available, of the potential benefits to herself and to her infant of knowing maternal serologic status. Communication of information about any positive test results to the biological parent(s) or the foster parent(s) should occur in a health care setting with appropriate social service support available at the time of the meeting. Infants who are identified as HIV-exposed (born to an HIV-infected woman) should be managed in accordance with established guidelines.⁹

HIV TESTING OF CHILDREN IN FOSTER CARE WHO ARE OLDER THAN 1 YEAR

HIV-infected children may remain asymptomatic for years or have mild nonspecific symptoms (anemia, poor growth, developmental delay) that are not recognized as secondary to HIV infection. In a cohort of HIV-infected children, 32 (17.7%) of 181 HIV-infected children were first diagnosed at 4 years of age or older.¹⁹ In another cohort of 42 perinatally infected long-term survivors between the ages of 9 and 15 years, 36 had no symptoms until after the age of 4 years.²⁰ Two children with perinatally acquired HIV infection have remained asymptomatic for almost 13 years.^{21,22} In addition, transfusion-acquired HIV infection may be associated with an asymptomatic or a minimally symptomatic phase of illness, thus delaying diagnosis of HIV infection.²³ Because of the increasing recognition of HIV infection among older children, foster care agencies should create policies to facilitate testing of older children. Testing for HIV should be performed for all children in foster care with symptoms or physical findings compatible with HIV infection and for all children with a sibling or parent who is HIV-infected. Because factors that lead to placement of children in foster care frequently are associated with an increased risk of HIV infection in the child and parents, determining the status of all older children who are in the foster care system whose maternal serologic status is unknown may be prudent.

Diagnosis of HIV infection is made in a child 18 months of age or older when antibody testing by enzyme-linked immunosorbent assay and the Western blot technique is positive or when the child meets diagnostic criteria for the younger infant (positive HIV-specific diagnostic assays, ie, DNA PCR or viral culture on 2 separate blood specimens from the infant). Results of tests should be provided by the child's physician to foster parents, biological parents (if possible), foster care agency, and the child (if old enough to comprehend and if disclosure is appropriate to the developmental level of the child).²⁴

HIV TESTING OF SEXUALLY ABUSED CHILDREN

Annually, more than 125 000 children and adolescents are sexually abused in the United States, and sexual abuse has been the mode of acquisition of HIV infection in at least 26 children younger than 13 years.²⁵ As part of sexual abuse evaluation, laboratory testing when performed should include HIV testing. Testing for HIV should be performed at the time of the initial assessment with repeated serologic testing at 6 weeks, 3 months, and 6 months after the incident

of sexual abuse for children whose initial test results are negative.²⁶ Testing also should be repeated if symptoms suggestive of HIV infection occur. Foster care agencies should develop mechanisms to ensure that initial and follow-up serologic tests are obtained when indicated.

HIV TESTING OF ADOLESCENTS IN FOSTER CARE

HIV-infected adolescents may be unaware of their infection status. Adolescents in foster care, just as those who are not in the foster care system, may acquire HIV infection as a consequence of their own sexual activity or illicit drug use or may have been infected by previous sexual abuse or, rarely, by perinatal transmission. Adolescents who have been victims of sexual abuse are more likely to engage subsequently in sexual behavior that may place them at increased risk for acquiring HIV infection and other sexually transmitted diseases.²⁷ Homeless adolescents frequently engage in prostitution in exchange for money, food, or shelter, and a period of homelessness may occur before an adolescent is placed in foster care. In a New York City shelter for homeless adolescents, 6% of the residents were seropositive.²⁸ Intravenous drug use has long been recognized as a risk factor for HIV infection. Cocaine use also has been reported as a risk factor for HIV infection because it may involve the exchange of sex for drugs or engaging in risky sexual behavior while under the influence of the drug.^{29,30} It is important, though, to recognize that the epidemiology of HIV infection is changing and that there is an increased incidence of HIV transmission in the adolescent population through homosexual and heterosexual contact.

For adolescents in foster care (as for adolescents who are not in foster care), HIV testing should be recommended for those who have symptoms or physical findings suggestive of HIV infection and for those who have any of the following known risk factors for HIV infection: a sibling, or parent who is HIV infected, a current or past sexual partner who is HIV-infected or at increased risk of HIV infection; receipt of a blood transfusion before 1985; a history of sexual abuse; a diagnosis of a sexually transmitted disease; or a history of illicit substance use or abuse. In addition, HIV testing should be considered for all adolescents in foster care who are sexually active or have a history of sexual activity and for those whose medical history and family history are unavailable or inadequate for assessment of the aforementioned risk factors. Evaluation should be performed in the context of provision of comprehensive adolescent health care, and all adolescents should receive education and counseling from a health care professional about prevention of transmission of HIV infection.

All states allow adolescents to consent to confidential evaluation and treatment for sexually transmitted diseases.³¹ In some states, adolescents may legally consent to confidential HIV testing and treatment. Testing of the adolescent should be performed with assent of the adolescent.³² If testing of the adolescent is performed in association with evaluation for sexual abuse or because of high-risk behavior, foster care agencies and physicians providing such care should ensure that appropriate follow-up testing is obtained. Communication of positive test results to the adolescent should occur in the health care setting. State regulations may require consent of the adolescent for disclosure of test results to other individuals or agencies participating in the adolescent's care.

ISSUES RELATED TO THE CARE OF HIV-EXPOSED AND HIV-INFECTED INFANTS, CHILDREN, AND ADOLESCENTS IN FOSTER CARE

Provision of Medical Care

Foster care agencies should periodically review, with physician guidance, the agency policies pertaining to the care of HIV-exposed infants and HIV-infected infants, children, and adolescents. In addition, periodic review should occur of policies related to acquisition and communication of medical information and other confidential information for those in foster care, including infants placed in foster care at the time of hospital discharge. It is the responsibility of the discharging physician to provide records, including confidential HIV-related information, to the physician designated to assume care or to the agency for provision to the physician who will assume care. Similarly, when a child or adolescent initially is placed in foster care, the agency should contact the physician providing care to obtain complete medical records and determine if there are acute or chronic medical problems that require medical follow-up, the immunization status, and whether the person is taking medication.

Maintenance of a "medical home" is important in the care of all foster children and is particularly beneficial for those with chronic health problems, such as HIV infection.³³ Foster care agencies should ensure, in the event of a change in physicians, that complete medical and immunization records are transferred to the new physician. Agencies providing foster care should minimize or eliminate barriers to sharing confidential information among counselors, mental health professionals, caseworkers, and the physician providing care to the child or adolescent. Comprehensive care for HIV-exposed infants and HIV-infected infants, children, and adolescents requires coordination of care among multiple

health care professionals and social service agencies. Use of the “health passport” (a booklet summarizing medical information, including illnesses, medications, immunizations, family history, and names of current and previous physicians) for children in foster care can assist in communication of information if the child changes physicians or is placed in a new foster home.³⁴

With the increasing identification of HIV infection among pregnant women, there also has been increasing use of prophylactic zidovudine to reduce the risk of perinatal HIV infection.³⁵ This regimen is considered safe for mother and child.³⁶ However, the longterm consequences of in utero exposure to zidovudine and other antiretroviral agents are unknown. It is critical that information about in utero exposure to antiretroviral drugs be included in the medical records of infants born to HIV-infected women. All such infants, whether infected or uninfected, should receive long-term follow-up.

Owing to rapid advances in management of HIV infection, involvement in clinical trials may provide benefit to HIV-exposed infants and HIV-infected infants, children, and adolescents in foster care. In addition, clinical trials that do not involve a therapeutic agent but provide long-term follow-up of HIV-exposed and HIV-infected children and adolescents provide important benefits. Agencies providing foster care should have established procedures for access to studies and to clinical trials.

Foster Parent Education

Foster care agencies should provide education about HIV to all foster parents as part of their initial training. Such education should be updated periodically and should include infection control guidelines for use in the home setting.³⁷ Foster parents should be aware that there may be HIV-infected infants, children, and adolescents in foster care whose HIV status is unknown. Foster parents providing care to HIV-exposed infants should be educated about all issues in the management of the HIV-exposed infant that usually are discussed with the biological parent.⁹

Because provision of medical care for HIV-exposed infants and HIV-infected infants, children, and adolescents is complex and requires frequent office visits, foster care agencies should develop procedures to ensure that those in foster care are seen at intervals deemed appropriate by the physician. If an HIV-exposed or HIV-infected child in foster care is transferred to a different foster home, the physician should be notified promptly (preferably before the transfer) to enable the physician to adequately inform the new foster parents about the child’s health care needs, provide ongoing medication, and assist with additional educa-

tion of new foster parents about HIV infection.

Permanency Planning

Although many children born to HIV-infected women are already in foster care or in the care of relatives outside the foster care system before the onset of debilitating complications in the mother or maternal death, infected women may not have made plans for provision of care for their children. In addition to determining who will provide care, it is necessary that provisions be made for long-term access to health care (physical and psychological) for HIV-infected offspring and for uninfected offspring. Permanency planning is a coordinated effort involving health care professionals, mental health professionals, social workers, foster care agencies, legal personnel, the biological family, and the designated "second family."³⁸

CONCLUSION

These recommendations about HIV testing of infants, children, and adolescents in foster care and for enhanced coordination of care by physicians and foster care agencies are made to provide maximal opportunity for those in foster care to benefit from the dramatic medical advances in the care of HIV-exposed and HIV-infected infants, children, and adolescents.

RECOMMENDATIONS

1. Physicians and foster care agencies should be jointly responsible for the determination of HIV exposure status and HIV infection status for all infants in foster care. If maternal serologic status during the most recent pregnancy is unknown, and the state has guardianship and the authority to consent to medical care, the infant should be tested for HIV antibody. Infants exposed to HIV should be managed in accordance with established guidelines.⁹
2. Testing for HIV should be performed for all children in foster care who have:
 - symptoms or physical findings suggestive of HIV infection;
 - been sexually abused;
 - a sibling who is HIV-infected; or
 - a parent who is HIV-infected or is at increased risk of HIV infection.

Testing for HIV also should be considered for all foster children whose maternal serologic status is unknown.

3. Testing for HIV (with assent of the adolescent) is recommended for all adolescents in foster care who have:

- symptoms or physical findings suggestive of HIV infection;
- a sibling who is HIV-infected;
- a parent who is HIV-infected or at increased risk of HIV infection;
- a current or past sexual partner who is HIV-infected or at increased risk of HIV infection;
- received a transfusion before 1985;
- a history of sexual abuse or a diagnosis of sexually transmitted disease; or
- a history of illicit substance use or abuse.

Testing for HIV also should be considered for all adolescents in foster care who are sexually active or have a history of sexual activity and for those whose medical history and family history are unavailable or inadequate for assessment of the aforementioned risk factors.

4. Physicians and foster care agencies should take joint responsibility to ensure appropriate exchange of complete medical records and confidential information necessary for the management of infants, children, and adolescents in foster care.
5. All foster parents should receive education about HIV infection, and the content of such education should be updated regularly.
6. All foster parents should be informed of the HIV exposure or infection status of infants and children in their care. Disclosure of adolescent HIV status should legally require the consent of the adolescent.
7. Foster care agencies should have established procedures to provide access for HIV-infected and HIV-exposed foster children to treatment-related and non-treatment-related clinical trials.

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