Advanced Primary Care for Children in Foster Care

Tamara M. Grigsby, MD
Carol Endo, MD
Dana R. Nason, MD
Commission to Eliminate Child Abuse & Neglect Fatalities

March 2016 Final Report

- 4-8 children die each day from abuse/neglect
- 50% < 12 mos; 75% < 36 mos
- Call to child protection hotline is best predictor of child’s potential risk for injury and death before age 3
- Nurse Family Partnership: only proven intervention
Health Care Issues for Children and Adolescents in Foster Care and Kinship Care

American Academy of Pediatrics
Dedicated to the Health of All Children

Policy Statement
Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
Dedicated to the Health of All Children

Technical Report

Health Care Issues for Children and Adolescents in Foster Care and Kinship Care

Grigsby, T. M.
October 11, 2017
Foster Child Placement Options

Kinship Care 26%, Foster Care 48%, Group Homes 15%, Supervised Independent Living 1%, Residential Treatment Facility, Hospitalization

- In 2013, estimated 3% of US children were living with kin because of the absence of their parents – the vast majority are voluntary arrangements

- In 2015, of 427,910 foster care children, 30% were in the kinship care of a relative

- It is uncertain how often pediatricians inquire about caregiver and guardian relationships during regular office visits

- Consent procedures vary widely among states
<table>
<thead>
<tr>
<th>Health Visit Type</th>
<th>Time After Entry; Location</th>
<th>Purpose</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Health Screening visit</td>
<td>Within 72 hours ED CARES/CAC PCP Office</td>
<td>1. ID health conditions requiring prompt attention 2. ID health conditions important in making placement decisions 3. Identify significant behavior issues important in making placement decisions</td>
<td>1. Appropriate treatment &amp; referral 2. Communication with caseworker 3. Anticipatory guidance re: transition to foster care, coping w/traumatized child, specific health issues</td>
</tr>
<tr>
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<tr>
<td>Add’l Foster Care Related Visits (see below)</td>
<td>Medical Home</td>
<td>1. Promote Wellness</td>
<td>1. Appropriate treatment &amp; referrals (MH, DEVO, EDU, Dental, Vision, etc.)</td>
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<td>2. ID significant problems – BH, MH, DEVO, school</td>
<td>2. Communication with caseworker</td>
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<td></td>
<td></td>
<td>3. Assess success of visitation, foster care placement, goodness of fit</td>
<td>3. Update treatment plan</td>
</tr>
<tr>
<td>Birth – 6 mos</td>
<td>2 wk, 2, 4, 6 mos*</td>
<td>*monthly if medical complexity</td>
<td></td>
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<tr>
<td>6-24 mos</td>
<td>9, 12, 15, 18, 24 mos⁺</td>
<td>+assess growth, behavior, development, etc.</td>
<td></td>
</tr>
<tr>
<td>21mos – 21 yrs</td>
<td>Every 12 months⁺</td>
<td>°ideal to see every 6 mos; more often if significant issues in any physical or mental health area</td>
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</tr>
</tbody>
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Grigsby, T. M.  
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Case Study #1

Biological Home

• Full term, SVD to 14 y/o G1P1
• Prenatal cannabis use
• 7 weeks age - removed from mom’s care for neglect – no immunizations, no well child care

Adoptive Foster Home

• Two moms – living in CA & OR
• Well Child Care 3 months age: WT 29%, L 32%, OFC 98%
• Routine WCC OFC>>WT, L
• 7/2/17 (13 months) to ED for focal seizure-> generalized tonic-clonic seizure; head imaging, noncontrast CT: acute versus subacute SDH with bilateral enlarged subarachnoid spaces of infancy (BESSI)
Case Study #1: Admit diagnosis CSDH; rule out NAT

- Full brain MRI confirms
  - resolving (non-acute) SDH; no underlying brain atrophy or pathology
  - Bilateral enlarged subarachnoid spaces of infancy (BESSI)
- Metabolic work up NEG
- Coagulopathy profile NEG/NL
- EEG normal
- Urine Drug Screen (UDS) negative
- Dilated eye examination NEG/NL
- 1\textsuperscript{st} Skeletal survey & 2\textsuperscript{nd} skeletal survey in 2 weeks: both NEG/NL
- Likely BESSI with chronic SDH,
  - indeterminate etiology, cannot confirm or exclude NAT
  - no historical risk factors for abuse identified in foster family
There is no smoking gun.

Screen for abuse & neglect at every health encounter

- HT, WT, HC; BMI > 2 years age
- Update problem list: frequent missed or cancelled appointments; non-compliance w/treatment
- Examine all body surfaces
- Include anogenital examination in preverbal and pre-school age children; in older children and youth, as warranted by history
- Any child disclosure or reasonable medical suspicion of abuse or neglect in a foster care placement must be newly reported to DHS
- Referral to child abuse pediatrician for comprehensive evaluation
Compared to Non-Kinship Foster Care

Kinship Foster Care

- Removed 2/2 parental substance abuse/neglect
- Single parent households
- Larger sibling groups
- Older foster caregivers w/disability, chronic conditions
- Foster caregivers w/less formal education
Compared to Non-Kinship Foster Care

**Kinship Foster Care**

- Poorer
- Not receiving benefits
- Less likely to have appropriate health insurance
- Uncertain guardianship agreements

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October 11, 2017
Compared to Non-Kinship Foster Care

**Kinship Foster Care**

- Less frequent displacement moves
- More likely to retain relationships w/extended family
- Outcomes improved the earlier kin assume care
- As much as 50% less likely to have behavioral problems several years after placement w/kin
Compared to the General Population

Kinship Foster Care:

- Higher rates of asthma, physical disabilities
- Poor eating habits
- Poor sleeping patterns
- Hyperactivity
- Less access to primary care, immunizations, vision, hearing, and dental care services
- Less likely to have outpatient behavioral and/or mental health examination
Identify families providing kinship care to better assess and meet the child’s needs

Clarify guardianship arrangements and consent information

More frequent follow up visits in the medical home

More intensive evaluations of developmental, behavioral, educational, and emotional status with appropriate referrals

Adopt pediatric healthcare guidance developed by AAP for foster care children, as standard of care for kinship children

Be aware of community resources & navigate families to them

Gains of kinship care children living with child welfare involvement have not always been realized by those kinship care children living without it.
Case Study #2

- 8 year old female, father deployed; mother struggling with drug and alcohol abuse
- Brought to WA to live with paternal uncle 6 weeks ago
- Enrolled and attending school
- No other medical records available from TX
- School teacher notices a facial bruise and contacts police
Case Study #2

• Risk of abuse is cannot be eliminated, even in foster care

• Review of outpatient and inpatient medical records is essential

• Despite overall better outcomes, kinship families face many hardships

• Pediatricians can provide a medical home and advocate for foster and kinship families
Foster Parents and Relative Caregivers

Foster parents and relative caregivers provide love and support to children in foster care. Children in foster care, although much like other children their age, often have special challenges and needs.

On this site you'll find information, training, policies and resources to support and help you as a foster parent.

Foster Parent Support Line
Available 24/7.
Phone: Dial 2-1-1 and listen for the parenting option.
Email: foster@211info.org

Training & Certification

New foster parents and relative caregivers in Oregon are required to take Foundations training to become certified.

Current foster parents and relative caregivers must complete continuing education training to fulfill licensing/certification requirements.

- Learn more about foster parent and relative caregiver training.

Manuals, Guides and Policies

- How to become a foster parent
- Foster Parent Orientation
- Relatives as Parents Resource Guide
- Legal Guide for Grandparents/Relatives Raising Children
- Rules, policies and protocols

Additional Resources

- Payment and rates
- Articles and insight about being a foster parent or relative caregiver
- Bill of Rights & Ethics
- More resources

O Oregon Foster Youth
Connection: Prudent Parent video
- English version, transcript
- Spanish version, transcript
The Foster Care Medical Home: Journey, not Destination
Lessons learned along the way

Carol Endo, MD
Staff Pediatrician
Randall Children’s Pediatric Clinic
October 11, 2017
Goals for this presentation

- Provide a framework for thinking about your practices and about your patients that are in foster care, with travel tips from our journey at Randall

- Show how the medical home concept for children with special health care needs can apply to children in foster care

- Learn about tools that may be helpful as you develop and refine your own foster care medical homes

- Share resources for children and families within the foster care system
“Life is a journey, not a destination.”

Lynn L Hough, Theologian or Steve Tyler, Aerosmith

Building a medical home for children in foster care is not a structure that gets completed, but a journey with discovery along the way.
Foster care: A statistical snapshot

- In 2015, 671,000 individual children in the United States were served by the foster care system¹,

- 270,000 children in the US entered foster care as of Sept 2015

- The mean length stay in foster care: 20 months

- The mean age at entry: 7.3 years
  - 48% entering foster care were 5 years and under
  - 24% were ages 6-11
  - 28% were 12-20

Foster Care in Oregon

- As of September 30, 2015, Oregon had 7,369 children in care
- 3,742 children entered the foster care system FY 2015
- 10,635 children were served by the foster care system in 2015
- Oregon ranked 22nd in the nation for total number of foster placements, and tied for 6th place in the rate per capita of foster care placements.

- It is likely that you will meet these children and their families at some point in your practice!

1. AFCARS 2016 report, State Data Tables
The start of our journey: The Portland Children’s Levy Medical Home Grant

- In 2008, the Portland Children’s Levy gave Emanuel Children’s Clinic a grant to develop medical homes for foster care children in the city of Portland.

- The goal: to create a coordinated system of care and become a true medical home for children in foster care.
“The American Academy of Pediatrics (AAP) advocates that all children, including children in foster care, should have a medical home that is accessible, and provides health care that is continuous over time, comprehensive, child-centered, coordinated, compassionate, and culturally effective.

For children in foster care, a medical home provider should understand the impact of childhood trauma on health and development and be an advocate for permanency and stability.”

Healthy Foster Care America
Grant + Goal = Perfect Medical Home?
...not exactly
My first patient in foster care came in with a trash bag of medications, and a guardian who didn’t know medications, health history, or why the child came into care.

I didn’t know how to contact caseworkers or who they were.

With every change in placement there was a high risk patients would no show appointments and get disenrolled from clinics or dismissed.

I “lost” a patient for a year when she was placed in another county, then another state...and then came back to me with none of her evaluations completed—I was alerted by a teacher concerned about unaddressed health needs.

...this did not feel like a medical home to me...
Moira Szilagyi’s list of what we can do as pediatricians to foster healthy futures for our children in care:

- **H**: Health Care in a Medical Home
- **E**: Education of parents and youth
- **A**: Advocacy
- **L**: Liaison with Child Welfare
- **T**: Tracking and coordination
- **H**: Holistic approach to child in foster care - the ecology of the child matters to their physical health
Children in foster care are children with special needs

- Fifty percent of children in foster care have chronic medical problems

- Ten percent of children are considered medically fragile.

- Children in foster care have a higher percentage of untreated dental problems

- Children in foster care have a higher prevalence of mental health problems, and a greater number of them are on psychotropic medications.

- Exposure to ACES increases risk of health problems. ACES of 6 or more can decrease lifespan by 20 years; ACE score of 4 increases risk of chronic bronchitis by 400%, risk of suicide by 1200%

- Children that have been foster care have a higher risk of homelessness and are more likely to drop out of school

Healthy Foster Care America: Health Issues and Needs
Being in foster care can make medical care delivery more complicated

- Issues in caring for children in foster care
  - Lack of records
  - Lack of communication between agencies and specialties
    - Children are sometimes started on treatment, but lack of communication may result in additional medications, or conflicting medications
  - Lack of follow through due to transitions in placement, missed appointments
  - The stress and instability that can come up in foster care can make physical and psychological problems worsen
  - Difficulty of separating behavioral/developmental/medical problems from trauma: [The Medical Home Approach to Identifying and Responding to Exposure to Trauma](#)
Step one: Start with your Why

From Simon Sinek’s: Start with Why and Find your Why

…” all parents, regardless of their own childhood adversity or system involvement, deserve the opportunity to experience the joy and happiness that parenthood brings. If we are to truly address the impact of trauma and interrupt its generational transmission, we must ensure they have the resources and tools to begin their parenting journeys with the best possible start.”

Sarah Pauter, Founder & CEO, Phenomenal Families

- PhenomenalFamilies

- All children deserve the best possible start, regardless of background or system involvement

- These kids and families deserve great care!
Step Two?

“Count something.”

Atul Gawande, The Checklist Manifesto

- Count our patients: Who are we serving?
  - How many are there?
  - Where are they?
  - What kind of health problems do they have?
  - Ages?

- Count our resources: Who’s on my team, and what do I have already?
  - Case managers/nurse managers
  - Clinical champions
  - Care notebooks—they are available online!

- Count our needs/what’s on our to-do list: What will help me take better care of my patients?
  - Are there “subcontractors” to help do jobs I’m not good at?
  - If a kid can’t get a resource, do we have ways to get it?

Checklists are helpful—and they exist for foster care medical homes!
Start with one thing: Holly Hermes, our care coordinator, helped us start tracking our patients, and helped develop critical connections with DHS.

If you already are a medical home for complex health needs, you can be a foster care medical home!

“Foster medical home” is really a “well coordinated medical home” for a child with complex health needs, one of them being in foster care

Foster care, and circumstances that result in a child placed into care, are ACES. Learning about trauma, ACES and resilience can be really helpful

“Remember, people will judge you by your actions and not your intentions. You may have a heart of gold but so does a hard-boiled egg.”
- Maya Angelou
When you find your “one thing” to start with, you don’t have to go it alone:

- Healthy Foster Care America Resources Library
- National Center for Medical Home Implementation
- Fostering Health is a freely downloadable book on the AAP site, for members and nonmembers alike: Fostering Health Downloadable guide
- Watch Moira Syzilagi’s presentation about fostering healthy futures: Fostering Healthy Futures: Health Needs of Children in Foster Care
# Healthy Foster Care America’s checklist for foster care

<table>
<thead>
<tr>
<th>Place at the front of chart</th>
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<tbody>
<tr>
<td>Child’s Name:</td>
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<tr>
<td>Date of birth:</td>
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<tr>
<td>Number of placements:</td>
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</table>

<table>
<thead>
<tr>
<th>Caseworker name:</th>
<th>Office phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax:</td>
<td>Address:</td>
</tr>
<tr>
<td>Cell phone:</td>
<td>Home phone:</td>
</tr>
<tr>
<td>E-mail:</td>
<td>Cell phone:</td>
</tr>
</tbody>
</table>

### PLACEMENT GOAL:
- [ ] Reunification
- [ ] Adoption
- [ ] Guardianship
- [ ] Kinship care
- [ ] Independent living

### HEALTH HISTORY

#### Chronic health diagnoses:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date of diagnosis</th>
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#### Medications for chronic conditions:

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
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#### Acute issues:

<table>
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<tr>
<th>Issue</th>
<th>Date</th>
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#### Allergies:

<table>
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<tr>
<th>Allergy</th>
<th>Date</th>
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#### Immunization records obtained:

- [ ] Up-to-date
- [ ] Not up-to-date
- [ ] No records

### HEALTH SUPERVISION

Please note the following should take place every visit:

- Every month for the first 6 months of age
- Every 3 months from 6 months to 2 years of age
- Twice a year after 2 years of age

#### For All Children and Teens
- Physical health and growth
- Plot growth, BMI (NC until age 3)
- Chronic medical needs
- Hearing/vision
- Dental
- Nutrition
- Immunizations
- Relationship issues (foster family, birth family, etc)
- Adjustment to placement, visits, etc
- Developmental/school needs/functioning

#### For Children and Teens (2 years of age and older)
- Normalizing activities
- Foster parent support
- Permanency plan
- Foster parent needs
- Services (eg, Medicaid/SSI, mental health, early intervention, special education/IEP)
- Summary for caseworker
- School adaptation and function
- Monitor for child abuse/neglect
- Behavior/emotional issues that may have arisen

### COMPREHENSIVE ADMISSION HEALTH ASSESSMENT (Within 30 days of placement)

**Date of assessment:**

- [ ] Screen for signs of child abuse and neglect
- [ ] Further identification of chronic health issues
- [ ] Treatment plan shared with caseworker and foster parent

#### Comprehensive mental health evaluation

<table>
<thead>
<tr>
<th>Practitioner:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Treatment plan:</td>
<td></td>
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<table>
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<tr>
<th>Ongoing service provider:</th>
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#### Comprehensive developmental evaluation (if under age 5 years)

<table>
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<tr>
<th>Practitioner:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Treatment plan:</td>
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<table>
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<tr>
<th>Ongoing service provider:</th>
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#### Comprehensive educational evaluation (if 5 years or older)

<table>
<thead>
<tr>
<th>School:</th>
<th>Date of evaluation:</th>
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<tbody>
<tr>
<td>Individual education plan:</td>
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</table>

#### HIV risks assessment

- [ ] Screening if risk assessment is positive

#### Other recommended laboratory tests at entry to foster care

- [ ] HEP B screen
- [ ] HEP C screen
- [ ] RPR
- [ ] Hemoglobin
- [ ] PPD
- [ ] Lead (under age 6 years)
What I wish I’d known at the beginning of the journey…

- The 10 things every pediatrician should know
- About Toxic stress and ACES, and how it can affect a child’s health
- The patients and families that you serve can be your partners in building a medical home—it’s their home, too
- I wish I knew how big the foster care community was, and this is a journey that you don’t need to take alone
Resources and websites

- Center for Youth Wellness: http://www.centerforyouthwellness.org/
- Embrace Oregon/For Every Child: http://www.embraceoregon.org/
- Shoulder to Shoulder http://www.stsconference.com/
  - STS conference is Monday October 30
- ACES/Toxic stress information:
  - https://www.resiliencetrumpsaces.org/
  - https://acesstoohigh.com/
  - http://www.acesconnection.com/
  - https://developingchild.harvard.edu/
- Resources for children in foster care
  - Foster Youth Connection: https://oryouthconnection.org/
  - Foster Youth Alumni: https://fostercarealumni.org/
  - FPNO: http://fpno.org/
  - Project Lemonade: http://www.projectlemonadepdx.org/
  - Together We Rise: https://www.togetherwerise.org/
  - Boxes of Love: http://www.boxesofoveproject.org/
  - New Avenues for Youth housing for children in foster care
“What good is an idea if it remains an idea? Try. Experiment. Iterate. Fail. Try again. Change the world.”

Simon Sinek
Thank you!
Foster Care Medical Home Model

Implementation at the clinic level
“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.”

Fostering Health: Health Care for Children and Adolescents in Foster Care, 2nd edition 2005
The Foster Care Medical home models reflects best practices.

But......

Where to start? There are usually several “right” ways to do things. Our experience with the model should open discussions about your way.
Every clinic has different strengths to build on.

Who are the children in foster care?

What services are you already providing?

What internal resources do you have to improve services?

How can you leverage external resources to add services?
Elements of Foster Care Medical Home

Identification and monitoring of children receiving foster care services.
Elements of Foster Care Medical Home

Dedicated care coordination that includes active outreach, collaboration, family engagement, team planning, child advocacy, and provider support.
Elements of Foster Care Medical Home

Education for parents, staff, and providers on trauma informed care/parenting.
Elements of Foster Care Medical Home

Standardized care that aligns with AAP guidelines for the population.
Elements of Foster Care Medical Home

Connected to community resources and referral options.
Elements of Foster Care Medical Home Integration with mental health.
Elements of Foster Care Medical Home

Integration with oral health.
Elements of Foster Care Medical Home

Transition support for children entering custody, during placement changes, and to permanency or adulthood.