



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

COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COMMITTEE ON ADOLESCENCE, and COUNCIL ON EARLY CHILDHOOD

Children and adolescents who enter foster care often do so with complicated and serious medical, mental health, developmental, oral health, and psychosocial problems rooted in their history of childhood trauma. Ideally, health care for this population is provided in a pediatric medical home by physicians who are familiar with the sequelae of childhood trauma and adversity. As youth with special health care needs, children and adolescents in foster care require more frequent monitoring of their health status, and pediatricians have a critical role in ensuring the well-being of children in out-of-home care through the provision of high-quality pediatric health services, health care coordination, and advocacy on their behalves.

abstract

FOSTER CARE IN THE UNITED STATES

The foster care system in the United States evolved over the last century as a means of providing care and protection to children and adolescents removed from their family of origin (predominantly for reasons of abuse and/or neglect and imminent safety concerns). The goal of the foster care system is to provide for the health, safety, and well-being of children and adolescents while fostering reunification or an alternative permanency arrangement (adoption, guardianship, placement with relatives, or independent living) when reunification is not possible. In this statement, the term “foster care” includes those living in court-ordered or formal kinship care (children living with extended family or kin), and the term “children” refers to children and adolescents from birth to 21 years of age. However, children remaining at home after a child protective services investigation experience many of the same childhood adversities as children in foster care and share many of the same health needs. Therefore, although the ensuing discussion and recommendations focus on children in foster care, they are relevant to all children who come into contact with the child welfare system.^{1,2} More complete information about health care for this population is available in the accompanying technical report.³

FREE

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

www.pediatrics.org/cgi/doi/10.1542/peds.2015-2655

DOI: 10.1542/peds.2015-2655

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2015 by the American Academy of Pediatrics

In 2013, approximately 641 000 children ranging in age from 0 to 21 years spent some time in foster care, a number that has steadily declined from a peak of 814 586 in 2002.⁴ The majority of children entering foster care have lived in deprived and chaotic environments for a significant period of time until removal for imminent safety concerns secondary to maltreatment. More than 70% of children in foster care have a documented history of child abuse and/or neglect,⁵ and more than 80% have been exposed to significant levels of violence, including domestic violence.⁶ In addition, even before entering foster care, many children have experienced multiple caregivers, limiting their ability to form a stable attachment to a nurturing caregiver. Removal is emotionally traumatizing for almost all children,^{7–10} although for some, it is the first time they may feel safe. Understanding the effects of multiple adversities, trauma, and toxic stress on the health and development of children is fundamental to guiding their caregivers through the healing process.

THE HEALTH NEEDS OF CHILDREN AND ADOLESCENTS IN FOSTER CARE

The significant unmet health needs of children and adolescents in foster care are rooted in their complex trauma histories and compounded by their poor access to appropriate health care services.^{1,7,10–15} Limited health care access and unmet health needs precede placement and often endure in foster care.² Data from the last 30 years demonstrating the high prevalence of health problems have led the American Academy of Pediatrics (AAP) to classify children in foster care as a population of children with special health care needs. Health is defined broadly in this population and includes medical, mental health, developmental, educational, oral, and psychosocial well-being. Overall, 30% to 80% of

children come into foster care with at least 1 medical problem,^{1,16–18} and one-third have a chronic medical condition. It is common for such problems to have gone undiagnosed and untreated before these children enter foster care. Up to 80% of children and adolescents enter with a significant mental health need,^{1,7,8,10} and almost 40% have significant oral health issues.¹⁸ Approximately 60% of children younger than 5 years have developmental health issues, and more than 40% of school-aged children have educational difficulties.¹⁹ Children in foster care are more likely to change schools during the school year, be in special education, and have a history of grade retention.²⁰ Adolescents in foster care have poor educational outcomes: high school dropout rates are nearly 3 times higher than those among other low-income children, and just over 50% graduate from high school, many with an equivalency diploma. Early data indicate that youth living in states where the age of emancipation is 21 years instead of 18 years have slightly higher educational achievement. Overall, 6% of foster care alumni have at least some college education, but only 1% to 2% graduate with a 4-year degree.^{20,21}

Essentially all children in foster care have psychosocial issues related to family dysfunction. Long-term outcomes of foster care have been inadequately studied, but national data suggest that young adults who were in foster care as adolescents experience high rates of mental health problems, unemployment, homelessness, low educational attainment, and posttraumatic stress disorder.^{22–26} Although far less is known about the outcomes of younger children who left foster care before adolescence through reunification with parents, placement with relatives, or adoption, there is evidence that children in long-term stable foster/kinship care do better

than those with unstable placements.²⁷

Early childhood trauma/toxic stress, especially if frequent or unremitting and not tempered by responsive, nurturing caregiving, adversely affects the neurobiology of the developing brain.^{28,29} Early childhood trauma has been correlated with poor emotional regulation, aggression, hyperactivity, impulsivity, attention and attachment problems, and the inability to associate thought and mood.⁸ Chaotic, unresponsive caregiving before foster care is associated with insecure attachment disorders that may present as indiscriminate friendliness, hypervigilance, or social withdrawal.

Ideally, children receive a full mental health evaluation, including a trauma assessment, shortly after entering foster care.³⁰ A mental health screening to assess for suicide risk and acute mental health needs is important at entry to care, but a full evaluation is probably best conducted after the child has had some time to adjust to his or her new living situation and visitation with family. Treatment, if indicated after evaluation, should incorporate appropriate therapy, including trauma-informed care, with appropriate education and support of the child's caregivers and caseworker. Parent-child interaction therapy, child-parent psychotherapy, trauma-focused cognitive behavioral therapy, and the attachment, self-regulation, and competency model^{30–33} are some recommended evidence-based trauma therapies that are unfortunately still not widely available. There is a shortage of mental health professionals with appropriate training in trauma-focused therapies, and funding is insufficient to ensure that all children who might benefit from these interventions can access them. Training in childhood trauma for caseworkers and foster parents has improved in recent years, but ongoing

support for foster parents by well-educated professionals is of great importance.

Pediatricians caring for children in foster care will often be asked to prescribe psychotropic medications for children with behavioral problems and/or they will encounter children on psychotropic medication. It can be challenging to discern the appropriateness of psychotropic medication for those children with multiple mental health diagnoses. The use of psychotropic medication to manage the behavioral and mental health problems of children in foster care has come under scrutiny in recent years, as data suggest that children in foster care are prescribed psychotropic medications at a rate 3 times that of other children enrolled in Medicaid and have higher rates of polypharmacy.³⁴ Children in foster care are also likely to receive longer treatment regimens than children who are enrolled in Medicaid but not in foster care.³⁵ Some children clearly benefit from psychotropic medications when appropriately prescribed, but concern exists that some children are not receiving appropriate mental health and trauma assessments before treatment and that medications are sometimes prescribed in lieu of evidence-based trauma care and other mental health interventions.³⁴ Concern over these issues, coupled with the fact that the majority of psychotropic medication prescriptions for children constitutes off-label use, prompted a report in November 2011 by the US Government Accountability Office calling for increased oversight of these medications by states and subsequent federal legislation mandating greater oversight by states (Child and Family Services Improvement and Innovation Act of 2011 [Pub L No. 112-34]).³⁶ In addition, there are concerns about the effects of psychotropic medications on the developing brain as well as the adverse effects (eg, obesity,

hyperlipidemia) of some of these medications.

It can be challenging for primary care providers to discern the suitability of prescribing psychotropic medications in a population with tremendous mental health needs. Optimal care for mental health concerns in a traumatized population includes a thorough mental health evaluation, including trauma assessment and assessment for comorbidities. Treatment should be diagnosis-specific and, ideally, evidence-based. Psychotropic medications, if indicated, should be initiated at low doses and titrated slowly, with close monitoring for efficacy and adverse effects. Polypharmacy should be avoided if possible. No patient should receive therapy with more than 1 psychotropic medication from any given class.³⁷

Foster parents remain the major therapeutic intervention of the foster care system. Stable placement with a warm, nurturing, empathic, attuned caregiver is ideal. Caregivers may have birth, adoptive, and foster children in their homes at any given time, which can create inherent conflict. Even in a stable home, entries and exits of other children can be traumatizing for the child in foster care. The foster/kinship home environment,^{38,39} stability in a placement, kinship placement,²⁷ an empathic relationship among foster caregivers and birth parents,⁴⁰ and consistent quality visitation⁴¹ have been shown to improve³⁸⁻⁴⁰ (or are recommended by experts to improve⁴⁰) child outcomes.

BARRIERS TO RECEIPT OF ADEQUATE HEALTH CARE IN FOSTER CARE

Physician and nonphysician clinicians often face significant barriers in providing appropriate health care services to children in foster care. Health care for traumatized children is time-consuming and challenging. Care coordination is particularly difficult for children in foster care

because of the transient nature of the population and the diffusion of authority among parents, child welfare professionals, and the courts.^{7,8,10} Receipt of health care is often fragmented and crisis-oriented rather than planned, preventive, and palliative. Evidence indicates that foster parents and caseworkers may not fully appreciate all of a child's health conditions and lack the expertise to access and negotiate a complex health care system on behalf of children with significant needs.¹² Pediatricians are, in general, equally unfamiliar with the structure, regulations, and intricacies of the child welfare system. Furthermore, in most communities, there are no structures or systems for coordinating care across disciplines.

Key challenges pediatricians may encounter while providing care for a child in foster care include:

- Incomplete or unavailable health information, including: information about immunizations; newborn health screening results; medications; allergies; chronic illnesses; hospitalizations; surgeries; vision or hearing loss; family history; dental history; psychosocial history, including childhood trauma history; and developmental or educational problems. The child is frequently accompanied by individuals (caseworkers, transporters, and new foster parents) who have little to no knowledge of the child's current medical or social situation.
- Difficulty identifying who has the authority to consent for health care on behalf of the child.
- Inadequate resources for evaluation and treatment. This limitation is a combination of workforce, systems, and funding issues. Medicaid (either fee-for-service or managed care) is the primary health care coverage for children in foster care but may impose limits on certain health services, especially subspecialty, dental, and mental health care.^{14,15,42,43}

COMPONENTS OF KEY HEALTH CARE SERVICES

There is abundant literature documenting the health needs of children in foster care and a growing body of literature on effective mental health interventions. However, recommendations regarding care coordination, early and frequent pediatric visits, and mental health, dental, developmental, and educational assessments represent consensus among experts in the field rather than recommendations based on research evidence because these topics have not been studied. There is consensus among experts that health care coordination, more frequent health visits during transitions, and the receipt of health services in the context of a pediatric medical home are fundamental principles in caring for this population.

Coordination of Care

Although health care coordination is necessary for improving health outcomes for children in foster care, only a few states and localities have systems for communication among caregivers, child welfare professionals, and health and mental health experts. Federal legislation, the Fostering Connections to Success and Increasing Adoptions Act (Pub L No. 110-351 [2008]), requires that states, in consultation with pediatricians and other health experts, develop systems for health oversight and coordination for children in foster care. This act outlines the important pieces of coordinated care: periodic health assessments, shared health information, provision of care in the context of a medical home, and oversight of prescription medications (particularly psychotropic drugs). The Child and Family Services Improvement and Innovation Act (Pub L No. 112-34 [2011]) built on the well-being provisions of the Fostering Connections to Success and Increasing Adoptions Act to support children's emotional and developmental health and to ensure

the oversight of psychotropic medications.

Information sharing is crucial to health care coordination. Several states have developed electronic data-sharing systems to improve communication among the child welfare and health care systems. Some states have adopted an abbreviated paper or computerized medical record, often referred to as a "health passport." For the child in foster care, the health passport should include the child's chronic health problems, allergies, medications, psychosocial and family histories, trauma history, and developmental and immunization information. Security can be built into such systems so that information is accessible depending on the professional's role in the care of the child or adolescent. Electronic health records, regional health information systems, and immunization registries offer new tools for improving communication.

Health Assessment at Entry Into Foster Care

Assessing each child's unique health needs at entry into foster care is critical, and pediatricians must be prepared to provide necessary care even when little or no specific information about the child's health history is available at the time of the visit. Ideally, every child would continue to receive health care in his or her medical home of origin. When this option is not possible, establishing and maintaining continuous, comprehensive, and coordinated care in a new pediatric medical home should be one of the highest priorities for child welfare agencies and pediatricians.⁴⁴ The child welfare professional is ultimately responsible for obtaining and making the child's health information available, but pediatricians may be able to assist in obtaining some information from schools, previous health care providers, immunization registries,

and regional health information organizations.

Medical Home

Children entering foster care have often had limited access to preventive and other health services before placement or have sought care from multiple health resources and may continue to receive fragmented care because of transitions in foster care placements.^{45,46} Thus, enrollment in a medical home is imperative to ensure the receipt of high-quality, comprehensive, coordinated health care that is continuous over time, compassionate, culturally competent, family centered, and child focused.⁴⁷ The medical home should provide uninterrupted care, regardless of the placement transitions a child may experience. Ideally, payment structures need to be aligned with the recommended health parameters for addressing the health needs and improving the health outcomes of this special needs population. The Patient Protection and Affordable Care Act (Pub L No. 111-148 [2010]) supports the expansion of the medical home model to meet the health needs of all patients, particularly those with complex health problems. Furthermore, given the similar health needs of all children who have been involved with the child welfare system, enrollment in a pediatric medical home should be prioritized by both the child welfare and health care systems.

Guidelines for Health Care Services

In 1988, the Child Welfare League of America, in consultation with the AAP, published guidelines for developing and organizing medical and mental health services for children in foster care. The *Standards of Excellence for Health Care Services for Children in Out-of-Home Care* were updated in 2007.⁴⁸ The AAP published detailed practice parameters for primary health care, developmental and mental health assessments, child abuse and neglect

screening, and health care management in 2005 in *Fostering Health: Health Care for Children and Adolescents in Foster Care*.¹³ This set of guidelines, developed by a panel of foster care health experts, is now available on the Healthy Foster Care America Web site,⁴⁹ and pediatricians caring for children in foster care familiar with these guidelines can assist child welfare administrators, caseworkers, and foster parents in ensuring that children's needs are met.

THE ROLE OF THE PEDIATRICIAN

Screening, Assessment, and Enhanced Visitation Schedules

Children entering foster care are ideally seen "early and often" to assess their health care needs, to document findings of child abuse or neglect, to support them and their families through the adjustment to foster care, and to ensure that all necessary referrals and services are in place. The AAP recommends an initial health screening within 72 hours of placement. However, younger or preverbal children, any child who is a suspected victim of abuse, or any child with a chronic medical or developmental condition should be seen within 24 hours. Ideally, children should have at least 3 health encounters over the first 3 months of foster care, as they adjust to their new circumstances. This schedule allows the pediatrician to monitor the child's adjustment to placement, to identify emerging needs, and to support the caregiver in helping the child. In addition to the initial health screen, experts recommend a comprehensive evaluation of each child's medical, dental, mental health, developmental, and educational needs within 30 days, resulting in a health plan that is shared with caregivers and child welfare professionals and integrated into the child's permanency plan. Thereafter, children in foster care, as

children with special health care needs, should be closely monitored.

In a system abundant with transitions and psychosocial stressors, it is recommended that children in foster care be seen monthly during the first 6 months of life, every 3 months from 6 to 24 months of age, and then at a minimum of every 6 months to monitor their health, emotional well-being, development, psychosocial stressors, continued adjustment to their foster family, and visitation with birth parents or other relatives. There are some children in stable, long-term foster care placement who are faring well and may not need such close monitoring. However, the default should be close monitoring with exceptions made as indicated based on the needs of the individual child and family. Transitions in placement, changes in visitation, and separation of siblings represent events that indicate a need for even closer monitoring. Because of their more intensive health needs, children in foster care may also require longer appointments. It is important to assess the child's overall health status, with a focus on developmental, educational, and emotional needs as well as the abilities of the child's caregiving environment to meet those needs at each and every health visit. Continued communication with the child's caseworker is essential to ensure implementation of the child's health plan and its integration into the child welfare permanency plan.

The Foster Care-Friendly Office

A foster care-friendly office is a trauma-informed office.³⁰ Pediatricians can welcome foster and kinship caregivers, caseworkers, and birth parents, when appropriate, to health visits and educate them about the effects of childhood trauma and adversity on a child's emotional and developmental health. Focusing all caregivers on working together on behalf of the child is an important role for pediatricians. The medical

home staff can provide information about managing health problems and emotional, behavioral, and developmental concerns; identify resources; and coordinate referrals. Pediatricians can be advocates for children in their care to ensure that each child's health needs are met, screen for signs of abuse and neglect at every health encounter, remain alert to the quality of the caregiver-child relationship, and share any concerns with the child's caseworker. Reframing child behavior issues in the context of childhood trauma and toxic stress and focusing on positive parenting principles and the child's strengths and talents can help to defuse caregiver distress and promote resilience. Recognizing and validating children's complex and often conflicted feelings about the caregiving adults in their lives can be reassuring for them; almost all children in foster care love and worry about their birth parents, even if they feel safer in foster care, and they also love and care about their foster and kinship caregivers.

The medical home can create a foster care-friendly environment by obtaining a copy of signed consents from the foster care agency and maintaining them as a part of the child's health record, having contact information for the child's caseworker in the child's chart, and sending a summary of the health visit that includes immunizations and other recommendations to the child's caseworker after each health care encounter. Child welfare professionals can assist with determining who has the authority to consent for health care services on behalf of a child and familiarize pediatricians with specific consent guidelines, including those regarding the prescription of psychotropic medications, when applicable. Adolescents in foster care have the same rights to confidential services as other teenagers. Another way to create a foster care-friendly office is to familiarize staff with the effects of childhood trauma so that all

staff members provide trauma-informed care and use trauma-informed language.

RECOMMENDATIONS

Recommendations for Practice Readiness

At the level of the individual pediatric practice, there are numerous opportunities to improve the quality of care that children in foster care receive. The AAP recommends that pediatricians:

- Advocate for children and adolescents in foster care to receive health care in a medical home.
- Become educated on the special health care needs of children and adolescents in foster care and assist other professionals in addressing these needs.
- Become educated on the unique microculture of foster care, particularly the effects of previous trauma/toxic stress, especially abuse and neglect, and the effects of ongoing uncertainty, transitions, and losses on children, teenagers, and families.^{28–30,50}
- Develop office systems for communicating with caseworkers, foster caregivers, and other professionals during or after each health encounter. Collaboration with the caseworker or the health care manager for the child is fundamental to ensuring that health needs are addressed.^{48,49,51}
- Become educated on state privacy, consent, and confidentiality laws affecting children and adolescents in foster care, including specific consent issues related to the administration of psychotropic medication.
- Incorporate the results of a child's comprehensive evaluation into a health care summary that is shared with the child welfare professional. Make a special effort to educate children and adolescents about their own health needs and care.

Recommendations Regarding Health Information Gathering

The child welfare caseworker is ultimately responsible for ensuring that the pediatrician has all needed health information. In reality, it is often difficult for the caseworker to obtain this information. Ideally, there is a health care manager who can contact schools, child care providers, former health care providers, health departments, immunization programs, or early intervention and/or Head Start programs to obtain and share health information on immunizations, newborn health screening results, hospitalizations, surgeries, allergies, chronic illnesses, medications, vision or hearing loss, family history, and developmental or educational evaluations when a child enters foster care.

The rapid advances in the development of the personal health record portion of the electronic health record hold great possibilities for information sharing in the foster care population. In fact, the highly mobile foster care population should be prioritized for dissemination and implementation of the personal health record because it would greatly help improve care coordination for these children and adolescents. Pediatricians may also want to check immunization registries and regional health information organizations for information about individual children. An encounter that includes the birth parent(s) is an opportunity to obtain a more detailed health history. In addition, pediatricians can encourage foster care agencies to send the foster parent, or at least a knowledgeable case manager, to a youth's appointment to facilitate the collection of health information.

Recommendations for Clinical Care

Child welfare caseworkers are also ultimately responsible for ensuring that children in foster care receive all appropriate and recommended health

care. However, navigating the health care system is challenging and complex, and child welfare caseworkers lack the necessary expertise for this function. Pediatricians can assist child welfare administrators, caseworkers, and foster parents in accessing appropriate health services (in addition to the standard preventive services outlined in Bright Futures)⁵² for children in foster care by becoming familiar with the standards in *Fostering Health: Health Care for Children and Adolescents in Foster Care*, available on the Healthy Foster Care America Web site.^{13,49} Recommendations for clinical care and their justification are summarized in Tables 3–6 of the accompanying technical report³ and include:

- All children and adolescents should have an initial health assessment (Table 3 in accompanying technical report³), ideally within 72 hours of placement; some children need to be seen within 24 hours, as noted previously.
- All children and adolescents should have a comprehensive evaluation of their medical, mental health, developmental, educational, and oral health status (Table 4 in accompanying technical report³) within 30 days of placement.
 - Ideally, all children should receive developmental, educational, and/or mental health evaluations, but priority should be given to children with needs identified through screening when resources are limited.⁵¹
 - The importance of good dental care should be communicated to foster parent(s) and older children and adolescents in foster care.
- Child welfare professionals should incorporate the results and recommendations of comprehensive assessments into the child's court-approved social service case plan (often called the permanency plan)

to ensure that the multiple health needs of children and adolescents in foster care are addressed.

- All children and adolescents should have a follow-up health assessment (Table 5 in the accompanying technical report³) within 60 to 90 days of placement.
- Every health encounter, especially periodic preventive health visits, presents opportunities for pediatricians to screen for signs of abuse or neglect, including poor weight gain, lack of warmth between the child and foster parent, frequent missed or canceled appointments, and failure to comply with health recommendations.
 - Height and weight (and head circumference for children aged <3 years) should be measured and plotted on the growth curve, and BMI should be calculated beginning at age 2 years.
 - All body surfaces should be examined for burns, bruises, scars, deformities, and limitation of joint movement.
 - A genital and anal examination should be performed by the most experienced provider available (ideally an expert in child sexual abuse), especially for preverbal children.
 - Clinical judgment should be used regarding the timing of the examination. Ideally, it would be done at the initial visit but in cases in which the child is distressed and/or there is little concern regarding sexual abuse, the examination can be delayed until the comprehensive visit.
 - If concerned about sexual abuse, testing for HIV and other sexually transmitted infections should be performed.
 - Physical signs of abuse or neglect should be documented in writing and with photography of affected areas.
- Any suspicion of abuse or neglect in a foster placement should be reported to child protective and foster care caseworkers.
- Pediatricians have a role in educating foster caregivers, caseworkers, birth parents, and adoptive parents about a child's health issues, the treatment plan, and the importance of providing predictable nurturance, normalizing activities, and the maintenance of similar routines and expectations across environments. Pediatricians also have a role in providing health information to judges, mental health professionals, child care providers, and early intervention specialists about the child's health issues. Caseworkers, as the case managers, need to be informed about changes in the child's health and are responsible for sharing information with the birth parent, child's attorney, and the court.
- Pediatricians should immunize children in foster care per AAP recommendations. Children and adolescents entering foster care are likely to be incompletely immunized, and determining the immunization status of a particular child may be challenging. Direct communication with previous physicians and review of school, child care, and immunization registry records increase the probability of accurately reconstructing the immunization history. Despite thorough effort, little or no immunization information will be available for some patients, who should then be considered susceptible and should be immunized according to AAP recommendations. Consent for immunization administration is usually covered in the general medical consent signed by the birth parent/guardian at the time of removal, and the child welfare agency should provide a copy of that

consent to the medical home. In the absence of this signed consent, the pediatrician is advised to obtain permission for immunization administration through the child welfare agency administration according to its protocols. Foster parents do not have the right, under law, to refuse immunizations for children in foster care residing in their homes.

- The pediatric medical home can schedule more frequent health visits for children and adolescents in foster care to monitor the child's ongoing health needs and treatment, given the complexity of their health issues (see accompanying technical report³). For example, health visits around any change in caregiver (ie, discharge from foster care, change in foster care placement) are recommended to educate the new caregiver about the child's health issues.

Recommendations Regarding Health Care Coordination and Management

Health care coordination and management are ultimately the responsibility of the foster care agency/caseworker but require health care expertise. The pediatrician may assist child welfare professionals with gathering and interpreting health information, communicating information around each health visit, making timely referrals and informing child welfare professionals about them, and monitoring the child's health.

Recommendations for Advocacy at a System Level

Pediatricians can play an important role in advocating for policies that would improve the delivery of effective and integrated health services within their communities and states for children in foster care. Policy makers may need education about the amount and quality of health services that children in foster care require and about the structure of the systems that will promote

coordination of care across disciplines. Pediatricians choosing to do this work must understand regional and state laws and guidelines regarding health information, confidentiality, and consent for children in foster care. The AAP Division of State Government Affairs (available at stgov@aap.org) can be contacted for more information on related state laws. The following list contains some policy goals for discussion with policy makers:

1. Pediatricians and mental health professionals should be included in interdisciplinary team meetings with state and local child welfare in developing the health care coordination and oversight plans mandated by federal law and in promoting the connection of children in foster care to pediatric medical homes.
2. State and local child welfare systems should ideally appoint a medical director, preferably a pediatrician, responsible for the oversight and coordination of health care systems for children in foster care.
3. Pediatricians can advocate for enhanced education about childhood trauma, its impact on child development and behavior, and appropriate treatment, including evidence-based parenting education for foster parents and other caregivers, caseworkers and all professionals involved with children in foster care.
4. Pediatricians can advocate for realigning financial resources with evidence-based and promising treatments and interventions.
5. Pediatricians can help ensure that children who are moved by the state into a foster care program are tracked and immediately enrolled in and covered by Medicaid until age 21 years by using the Chafee option. Since 2014, youth aging out of foster care have the option to elect Medicaid coverage

under the Patient Protection and Affordable Care Act until 26 years of age.⁵³

6. Dedicated planning and oversight can be implemented when managed care organizations contract for care delivery for children with special health care needs (including children with complex and/or rare diseases, children with behavioral/mental health conditions, and children in foster care).⁵³

LEAD AUTHOR

Moira A. Szilagyi, MD, PhD

CONTRIBUTING AUTHORS

David S. Rosen, MD, MPH* – *Committee on Adolescence*

David Rubin, MD, MSCE – *PolicyLab at The Children's Hospital of Philadelphia*

Sarah Zlotnik, MSW, MSPH – *PolicyLab at The Children's Hospital of Philadelphia*

COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE EXECUTIVE COMMITTEE, 2014–2015

Moira Szilagyi, MD, PhD, Chairperson

David Harmon, MD

Paula Jaudes, MD

V. Faye Jones, MD, PhD, MSPH

Paul Lee, MD

Lisa Nalven, MD, MA

Lisa Prock, MD, MPH

Linda Sağor, MD, MPH

Elaine Schulte, MD, MPH

Sarah Springer, MD

Thomas Tonniges, MD

LIAISONS

George Fouras, MD – *American Academy of Child and Adolescent Psychiatry*

Jeremy Harvey – *Foster Care Alumni of America*

Melissa Hill, MD – *AAP Section on Medical Students, Residents and Fellowship Trainees*

COMMITTEE ON ADOLESCENCE, 2014–2015

Paula K. Braverman, MD, Chairperson

William P. Adelman, MD

Elizabeth M. Alderman, MD, FSAHM

Cora C. Breuner, MD, MPH

David A. Levine, MD

Arik V. Marcell, MD, MPH

Rebecca O'Brien, MD

LIAISONS

Margo Lane, MD, FRCPC – *Canadian Pediatric Society*

Julie Strickland, MD – *Department of Obstetrics & Gynecology*

Benjamin Shain, MD, PhD – *American Academy of Child and Adolescent Psychiatry*

COUNCIL ON EARLY CHILDHOOD EXECUTIVE COMMITTEE, 2014–2015

Dina Lieser, MD, FAAP, Chairperson

Beth DelConte, MD, FAAP

Elaine Donoghue, MD, FAAP

Marian Earls, MD, FAAP

Danette Glassy, MD, FAAP

Terri McFadden, MD, FAAP

Alan Mendelsohn, MD, FAAP

Seth Scholer, MD, FAAP

Jennifer Takagishi, MD, FAAP

Douglas Vanderbilt, MD, FAAP

Patricia Gail Williams, MD, FAAP

LIAISONS

Abbey Alkon, RN, PNP, PhD, MPH – *National Association of Pediatric Nurse Practitioners*

Lauren Gray, MA – *National Association for the Education of Young Children*

Barbara U. Hamilton, MA – *Maternal and Child Health Bureau*

Claire Lerner, LCSW – *Zero to Three*

STAFF

Mary Crane, PhD, LSW

Karen Smith

Charlotte Zia, MPH, CHES

*Deceased

REFERENCES

1. Leslie LK, Gordon JN, Meneken L, Premji K, Michelmore KL, Gänger W. The physical, developmental, and mental health needs of young children in child welfare by initial placement type. *J Dev Behav Pediatr*. 2005;26(3):177–185
2. Ringeisen H, Casanueva C, Urato M, Cross T. Special health care needs among children in the child welfare system. *Pediatrics*. 2008;122(1). Available at: www.pediatrics.org/cgi/content/full/122/1/e232
3. American Academy of Pediatrics, Council on Foster Care, Adoption, and Kinship Care, Committee on Early Childhood, and Committee on Adolescence. Technical report: health care issues for children and adolescents in foster care and kinship care. *Pediatrics*. 2015;136(4). Available at: www.pediatrics.org/cgi/content/full/136/4/e1142
4. Children's Bureau, An Office of the Administration for Children & Families. AFCARS. Available at: www.acf.hhs.gov/programs/cb/research-data-technology/reporting-systems/afcars. Accessed October 22, 2014

5. Takayama JI, Wolfe E, Coulter KP. Relationship between reason for placement and medical findings among children in foster care. *Pediatrics*. 1998; 101(2):201–207
6. US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. The AFCARS Report. Preliminary FY 2010 estimates as of June 2011. Available at: www.acf.hhs.gov/programs/cb/resource/afcars-report-18. Accessed October 22, 2014
7. Hillen T, Gafson L. Why good placements matter: pre-placement and placement risk factors associated with mental health disorders in pre-school children in foster care. *Clin Child Psychol Psychiatry*. 2015;20(3):486–499
8. Szilagyi M. The pediatric role in the care of children in foster and kinship care. *Pediatr Rev*. 2012;33(11):496–507, quiz 508
9. Simms MD. Foster children and the foster care system, part I: history and legal structure. *Curr Probl Pediatr*. 1991; 21(7):297–321
10. Simms MD, Dubowitz H, Szilagyi MA. Health care needs of children in the foster care system. *Pediatrics*. 2000;106 (suppl 4):909–918
11. US General Accounting Office. *Foster Care: Health Needs of Many Young Children Are Unknown and Unmet*. Washington, DC: US General Accounting Office; 1995
12. Simms MD. The foster care clinic: a community program to identify treatment needs of children in foster care. *J Dev Behav Pediatr*. 1989;10(3): 121–128
13. American Academy of Pediatrics District II New York State Task Force on Health Care for Children in Foster Care. *Fostering Health: Health Care for Children and Adolescents in Foster Care*. Elk Grove Village, IL: American Academy of Pediatrics; 2005
14. Zlotnick C, Soman LA. The impact of insurance lapse among low-income children. *J Urban Health*. 2004;81(4): 568–583
15. Leslie LK, Kelleher KJ, Burns BJ, Landsverk J, Rolls JA. Foster care and Medicaid managed care. *Child Welfare*. 2003;82(3):367–392
16. Steele JS, Buchi KF. Medical and mental health of children entering the Utah foster care system. *Pediatrics*. 2008; 122(3). Available at: www.pediatrics.org/cgi/content/full/122/3/e703
17. Halfon N, Mendonca A, Berkowitz G. Health status of children in foster care. The experience of the Center for the Vulnerable Child. *Arch Pediatr Adolesc Med*. 1995;149(4):386–392
18. Chernoff R, Combs-Orme T, Risley-Curtiss C, Heisler A. Assessing the health status of children entering foster care. *Pediatrics*. 1994;93(4):594–601
19. Jee SH, Szilagyi M, Ovenshire C, et al. Improved detection of developmental delays among young children in foster care. *Pediatrics*. 2010;125(2):282–289
20. Barrat V, Berliner BA. *The Invisible Achievement Gap, Parts 1 and 2: Education Outcomes of Students in Foster Care in California Schools*. San Francisco, CA: The Center for the Future of Teaching and Learning; 2013
21. Dworsky A, Courtney M. Does extending foster care age beyond age 18 promote postsecondary educational attainment? Available at: www.chapinhall.org/sites/default/files/publications/Midwest_IB1_Educational_Attainment.pdf. Accessed June 15, 2015
22. Reilly T. Transition from care: status and outcomes of youth who age out of foster care. *Child Welfare*. 2003;82(6):727–746
23. Kerman B, Wildfire J, Barth RP. Outcomes for young adults who experienced foster care. *Child Youth Serv Rev*. 2002;24(5): 319–344
24. Pecora PJ, Kessler RC, Williams J, et al. *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study*. Seattle, WA: Casey Family Programs; 2005
25. Smithgall C, Gladden RM, Howard E, Goerge R, Courtney M. *Educational Experiences of Children in Out-of-Home Care*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago; 2004
26. Rushton A, Dance C. The adoption of children from public care: a prospective study of outcome in adolescence. *J Am Acad Child Adolesc Psychiatry*. 2006; 45(7):877–883
27. Harden BJ. Safety and stability for foster children: a developmental perspective. Available at: http://futureofchildren.org/futureofchildren/publications/docs/14_01_02.pdf. Accessed June 15, 2015
28. Garner AS, Shonkoff JP; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012;129(1). Available at: www.pediatrics.org/cgi/content/full/129/1/e224
29. Shonkoff JP, Garner AS; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1). Available at: www.pediatrics.org/cgi/content/full/129/1/e232
30. Forkey H, Szilagyi M. Foster care and healing from complex childhood trauma. *Pediatr Clin North Am*. 2014;61(5): 1059–1072
31. California Evidence-Based Clearinghouse for Child Welfare. Welcome to the California Evidence-Based Clearinghouse for Child Welfare. Available at: www.cebc4cw.org/. Accessed October 22, 2014
32. American Academy of Pediatrics and Dave Thomas Foundation for Adoption. *Helping Foster and Adoptive Families Cope With Trauma: A Guide for Pediatricians*. Elk Grove Village, IL: American Academy of Pediatrics; 2013. Available at: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf. Accessed July 18, 2015
33. American Academy of Pediatrics. *Trauma Toolbox for Primary Care*. Available at: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx. Accessed July 18, 2015
34. Zito JM, Safer DJ, Sai D, et al. Psychotropic medication patterns among youth in foster care. *Pediatrics*. 2008;121(1). Available at: www.pediatrics.org/cgi/content/full/121/1/e157

35. Dosreis S, Yoon Y, Rubin DM, Riddle MA, Noll E, Rothbard A. Antipsychotic treatment among youth in foster care. *Pediatrics*. 2011;128(6). Available at: www.pediatrics.org/cgi/content/full/128/6/e1459
36. US Government Accountability Office. *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Medications*. Washington, DC: US Government Accountability Office; 2011
37. Texas Department of Family and Protective Services and The University of Texas at Austin College of Pharmacy. Psychotropic medication utilization parameters for children and youth in foster care. Available at: www.dfps.state.tx.us/documents/Child_Protection/pdf/TxFosterCareParameters-September2013.pdf. Accessed October 22, 2014
38. Simms MD, Horwitz SM. Foster home environments: a preliminary report. *J Dev Behav Pediatr*. 1996;17(3):170–175
39. Fisher PA, Gunnar MR, Dozier M, Bruce J, Pears KC. Effects of therapeutic interventions for foster children on behavioral problems, caregiver attachment, and stress regulatory neural systems. *Ann N Y Acad Sci*. 2006; 1094(1):215–225
40. Redding RE, Fried C, Britner PA. Predictors of placement outcomes in treatment foster care: Implications for foster parent selection and service delivery. *J Child and Family Services*. 2000;9:425–447
41. Beyer M. Visit coaching. Available at: www.cffutures.org/conference_information/documents/VisitCoachingSummary.pdf. Accessed May 5, 2015
42. Simms MD, Freundlich M, Battistelli ES, Kaufman ND. Delivering health and mental health care services to children in family foster care after welfare and health care reform. *Child Welfare*. 1999; 78(1):166–183
43. Halfon N, Berkowitz G, Klee L. Children in foster care in California: an examination of Medicaid reimbursed health services utilization. *Pediatrics*. 1992;89(6 pt 2): 1230–1237
44. DiGiuseppe DL, Christakis DA. Continuity of care for children in foster care. *Pediatrics*. 2003;111(3). Available at: www.pediatrics.org/cgi/content/full/111/3/e208
45. Farmer EM, Mustillo SA, Wagner HR, et al. Service use and multi-sector use for mental health problems by youth in contact with child welfare. *Child Youth Serv Rev*. 2010;32(6):815–821
46. Johnson C, Silver P, Wulczyn F. Raising the bar for health and mental health service for children in foster care: developing a model of managed care. Council of Family and Child Caring Agencies and the New York State Health Foundation. Available at: www.cofcca.org/pdfs/FosterCareManagedCare-FinalReport.pdf. Accessed March 15, 2015
47. American Academy of Pediatrics, The National Center for Medical Home Implementation. What is a family-centered medical home? Available at: www.medicalhomeinfo.org/. Accessed October 22, 2014
48. Child Welfare League of America. *CWLA Standards of Excellence for Health Care Services for Children in Out-of-Home Care*. Arlington, VA: Child Welfare League of America; 2007
49. American Academy of Pediatrics. Healthy Foster Care America. Available at: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/default.aspx. Accessed October 22, 2014
50. Stirling J Jr, Amaya-Jackson L, Amaya-Jackson L; American Academy of Pediatrics; Committee on Child Abuse and Neglect and Section on Adoption and Foster Care; American Academy of Child and Adolescent Psychiatry; National Center for Child Traumatic Stress. Understanding the behavioral and emotional consequences of child abuse. *Pediatrics*. 2008;122(3):667–673
51. American Academy of Pediatrics. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*. Elk Grove Village, IL: American Academy of Pediatrics; 2010
52. Hagan JF Jr, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
53. American Academy of Pediatrics, Committee on Child Health Financing. Medicaid policy statement. *Pediatrics*. 2013;131(5). Available at: www.pediatrics.org/cgi/content/full/131/5/e1697

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

COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE and
COMMITTEE ON ADOLESCENCE, and COUNCIL ON EARLY CHILDHOOD
Pediatrics 2015;136:e1131

DOI: 10.1542/peds.2015-2655 originally published online September 28, 2015;

Updated Information & Services	including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/136/4/e1131
References	This article cites 30 articles, 12 of which you can access for free at: http://pediatrics.aappublications.org/content/136/4/e1131#BIBL
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): Current Policy http://www.aappublications.org/cgi/collection/current_policy Council on Foster Care, Adoption and Kinship Care http://www.aappublications.org/cgi/collection/section_on_adoption_and_foster_care Adoption & Foster Care http://www.aappublications.org/cgi/collection/adoption_-_foster_care_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: http://www.aappublications.org/site/misc/Permissions.xhtml
Reprints	Information about ordering reprints can be found online: http://www.aappublications.org/site/misc/reprints.xhtml

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



PEDIATRICS[®]

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

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

COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE and
COMMITTEE ON ADOLESCENCE, and COUNCIL ON EARLY CHILDHOOD
Pediatrics 2015;136:e1131

DOI: 10.1542/peds.2015-2655 originally published online September 28, 2015;

The online version of this article, along with updated information and services, is
located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/136/4/e1131>

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 345 Park Avenue, Itasca, Illinois, 60143. Copyright © 2015 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN[®]

