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

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abstract

Children and adolescents involved with child welfare, especially those who are removed from their family of origin and placed in out-of-home care, often present with complex and serious physical, mental health, developmental, and psychosocial problems rooted in childhood adversity and trauma. As such, they are designated as children with special health care needs. There are many barriers to providing high-quality comprehensive health care services to children and adolescents whose lives are characterized by transience and uncertainty. 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 in the context of a medical home, and health care coordination and advocacy on their behalf. This technical report supports the policy statement of the same title.

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INTRODUCTION

Goals of Foster Care

The foster care system in the United States evolved over the past century as a means of providing care and protection to children and adolescents removed from their family of origin for reasons of abuse and/or neglect. The goal of the foster care system is to promote the well-being of children and adolescents by providing for their health, safety, stability, and permanency. Stable placement in a nurturing foster or kinship setting is important, but the real goal of foster care is the achievement of permanency through reunification or an alternative permanent arrangement (adoption, guardianship, or placement with relatives). Child welfare professionals have the responsibility for helping youth who do not achieve permanency develop the array of skills needed for successful independent living.¹ In this document, the term “foster care” includes children in family foster care, congregate care, and court-ordered or formal kinship care (extended family or kin). The term “child” includes

infants, children, adolescents, and young adults up to age 21 years who reside in foster care. The reader should be aware that most children remain with their parents or extended family after child protective services investigation and may continue to be involved with child welfare through preventive services. The literature has shown that these children share the same risk factors for poor long-term outcomes as children in foster care; thus, much of the information in this report applies to children who have had child welfare contact in any capacity.^{2,3} The term “health” is used broadly and encompasses medical, emotional, mental, behavioral, developmental, educational, and oral health. This technical report accompanies a briefer policy statement.⁴

Trends in Foster Care

The Adoption and Safe Families Act (ASFA [Pub L No. 105-89]), enacted by Congress in 1997, dramatically shifted the focus of foster care from the rights of birth parents and reunification to the needs of children for health, safety, and permanency. Recognizing that children and adolescents need permanency, stability, and a sense of belonging in a family for optimal well-being, legislators increased adoption incentives and mandated that states begin proceedings to terminate parental rights when a child or adolescent has spent 15 of the previous 22 months in foster care, unless a compelling reason existed not to, such as impending reunification with the parent or extended family.

ASFA, along with shifts in child welfare knowledge and practice, resulted in several significant trends over the past 15 years. The number of children and adolescents in foster care decreased steadily from a peak daily census of approximately 524 000 in 2002, to fewer than a half a million per day in 2013.⁵ In 2013, the foster care system served

approximately 402 000 children per day, a year when 641 000 children spent at least some time in foster care.⁵ Over the past decade, child welfare professionals have made greater efforts to place children who need to be removed from their birth parents for safety reasons with extended family or “kin.” Thus, more children are living in such arrangements, with varying degrees of oversight.^{2,6} Adoptions out of foster care, most often by a foster parent or relative, increased several years after ASFA was enacted, and now number approximately 51 000 per year, accounting for nearly 20% of children exiting foster care annually. Nearly 102 000 children and adolescents were awaiting adoption at the end of 2013, more than half of whom were older children; children of racial or ethnic minority groups; children with large sibling groups; or children with complex emotional, behavioral, and developmental issues who do not have a potential adoptive parent identified.^{6,7}

The ASFA mandate for timely permanency reduced the average length of stay from 32.0 months to 25.3 months between 1999 and 2011.⁸ Ultimately, about 60% of children return to either their parent or to a member of their extended family; additionally, many children are adopted by kin caregivers, although most are adopted by a nonrelative foster parent.⁹ Children who remain in care beyond 12 months are likely to be older children, children of racial or ethnic minority groups, or adolescents with significant developmental or behavioral conditions.¹⁰ Infants and young children continue to have high rates of placement in foster care, longer lengths of stay, and higher recidivism (return to foster care), a particular concern, because they are at a critical stage of development and attachment formation.¹⁰⁻¹²

Recent legislative developments have furthered the goals of ASFA. In 2008,

the enactment of the Fostering Connections to Success and Increasing Adoptions Act (Fostering Connections Act [Pub L No. 110-351]) increased subsidies and supports for kinship care, guardianship, and adoption out of foster care and set out specific guidelines for states to improve educational stability and health care coordination for youth in foster care. The 2011, the Child and Family Services Improvement and Innovation Act (Pub L No. 112-34) built on and clarified well-being provisions in the Fostering Connections Act. Specifically, the 2011 law requires states to monitor emotional trauma for children removed from the home, better track and enact protocols for appropriate use of psychotropic medications, and report on steps they have taken to ensure developmental health for very young children in state care.

In addition to these reforms, recent child welfare legislation has prioritized the improvement of outcomes for the roughly 28 000 youth per year who “age out” of foster care, usually at age 18 years.⁸ The Foster Care Independence Act of 1999 (Pub L No. 106-169) gave states the option to continue providing some casework, housing, job training, and health resources to emancipated youth until 21 years of age. More recently, the Fostering Connections Act of 2008 (Pub L No. 110-351) increased subsidies and supports for youth emancipating from foster care. Further, in 2010, the Patient Protection and Affordable Care Act (Pub L No. 111-148) extended Medicaid eligibility to age 26 years beginning in 2014 for youth who age out of foster care; this act also requires child welfare professionals to work with emancipating youth to develop a health care transition plan.

The racial/ethnic profiles of the foster care population vary among communities, and the faces in foster care in any given community tend to reflect the faces of those living in

poverty. The race-ethnicity of children in foster care has shifted in the past decade, although minorities are still overrepresented. In 2011, 26% of children in foster care were black/non-Hispanic, 21% were Hispanic, and 6% were multiracial, reflecting a dramatic reduction of African American children since 1999.¹³ However, concern remains about possible bias in child maltreatment reporting and/or investigation, resulting in the removal of relatively more children of racial or ethnic minority heritage from their families.^{14,15}

There are a few subgroups of children in foster care deserving of special mention. A small but increasing group of adolescents in foster care are unaccompanied refugee minors, who have entered the United States alone from ravaged homelands, often with no information regarding the fate of their family. Speaking minimal English, and with limited education, they present with compelling challenges. Other groups with unique needs include those with significant cognitive impairment, who will enter permanent state guardianship as they reach adulthood; adolescents with criminal justice involvement; medically fragile children; and pregnant/parenting teenagers who may be placed with or apart from their child(ren), who may or may not also be in foster care.

Reasons for Placement

Removal of a child from his or her family most often occurs as a result of an imminent threat to child safety because of abuse and/or neglect. Seventy percent of children are placed in foster/kinship care by court order because of abuse and neglect that occurs in the context of parental substance abuse and addiction, extreme poverty, parental mental illness, transient living situations or homelessness, extreme family violence, and parental criminal activity.^{16,17} Adolescents may be placed by court order because of their

own behavioral and emotional issues or because of minor criminal involvement (juvenile delinquency or person in need of supervision). However, adolescents often come from chaotic, dysfunctional families who have some previous involvement with child protective services, and most teenagers also have been victims of abuse and/or neglect as children. Overall, less than 1% of children are placed voluntarily by their parents because of an interval family crisis, such as parental illness, incarceration, or hospitalization or because of a child's mental health needs. Parents requesting foster care placement are first offered alternative resources (preventive services) to prevent family disruption or placement with relatives in such circumstances.¹⁸ In summary, a disproportionate number of children placed in foster care come from families with the fewest psychosocial and financial resources and the most complex needs.

Type of Placement

Placement is mandated to be in the least restrictive environment to meet the child's needs, so most children reside in family foster care (48%) or kinship care (26%).⁸ In some communities, more than one-third of foster families are now kinship providers. The Fostering Connections Act requires that relatives be notified within 30 days of the child's removal from the parent, provides states increased supports for children living in kinship care or guardianship, and funds local kinship navigator programs. Although children placed in kinship care or guardianship have many of the same risk factors as children in nonrelative foster care, recent studies have shown that children living with extended family have greater placement stability and that caregivers report fewer behavior and developmental problems compared with children in nonrelative foster care.^{2,11,13,14,19} However, the prevalence of

behavioral problems for these children is still well above that of community peers, and their caregivers are more likely to be older and poorer and with even less access to services than nonrelative foster caregivers.^{2,19,20} Appropriate services and treatment may strengthen the stability of placements, both foster and kinship, and improve child outcomes over the long term.²¹

Children and adolescents also may reside in other caregiving arrangements. Approximately 15% of the foster care population, nearly all of them adolescents with significant mental health and behavioral problems, reside in either group homes or residential treatment facilities.^{8,22} An additional 1% of youth live in supervised independent living, a program intended to prepare adolescents for emancipation from foster care.⁸

RISK FACTORS FOR POOR OUTCOMES

Research on early brain development has shown that infancy and early childhood are critical periods during which the foundations for attachment, trust, self-esteem, conscience, empathy, problem solving, focused learning, and impulse control are formed.²³⁻²⁶ Evidence is accumulating that early childhood trauma and adversity, especially if frequent or unremitting and not tempered by care from a responsive, attuned, nurturing caregiver, affect the neurobiology of the developing brain.²⁷⁻²⁹ It is now known that toxic stress alters genetic expression in ways that alter the very architecture of the brain. Those areas of the brain most affected (the amygdala, hippocampus, and right prefrontal cortex) are those involved in stress response, emotional regulation, attention, cognition, executive function, and memory. Thus, childhood trauma, adversity, and toxic stress are correlated with poor emotional regulation, aggression, hyperactivity, inattention, impulsivity,

and dissociation between thought and emotion. Research in adults has shown increased morbidity and mortality among those who experienced a higher number of adverse childhood experiences.^{30,31}

Resilience in childhood is rooted in nurturing care provided over time by a responsive, attuned caregiver who mediates the world for a child in ways that promote healthy adaptation. Children can withstand significant life stressors if raised in a milieu in which the caregiver is protective, nurturing, and promotes self-efficacy.³²⁻³⁴

Evidence indicates that children and adolescents fare best when raised in stable homes with nurturing caregivers who respond to their needs and provide reasonable structure.³² Children and teenagers also benefit from safe and reasonable child care, and educational and neighborhood settings and exposure to normalizing activities.^{29,33,34}

Unfortunately, children and adolescents entering foster care have most likely lived in deprived, chaotic environments for significant periods of time. Many birth families have a long history of child protective services involvement and may have failed multiple preventive services before their children are finally removed for reasons of safety. Children and adolescents entering foster care are most often the children of the poor; their lives are characterized by multiple chronic adversities known to have synergistic negative effects on long-term outcomes.^{1,35-37} More than 70% have a documented history of maltreatment,¹⁶ and over 80% have been exposed to significant levels of violence, including domestic violence.³⁸ Inadequate and chaotic caregiving is common, as many birth parents have high rates of mental illness, substance abuse/addiction, and criminal justice involvement rooted in their own childhood trauma experiences.^{39,40} One study of 3- to 10-year-old

children in foster care demonstrated that 11% of birth parents were cognitively impaired.³⁹ Extrafamilial risk factors predictive of poor long-term outcomes include homelessness or near homelessness, a dearth of normalizing activities, attendance at poor/unsafe schools or child care settings, poor school attendance, and unsafe homes/neighborhoods in which children are exposed to criminal activity, violence, drug selling, drug use, theft, assault, prostitution, and pornography.⁴⁰ In addition, many have experienced multiple caregivers before entering foster care, so they have not formed the stable attachment over time to a nurturing caregiver that is the foundation for future healthy relationships.

The Effects of Foster Care on Children and Families

Removal from the family and all that is familiar is emotionally traumatic for almost all children and may compound the effects of multiple preplacement adversities.^{1,41-43} Foster care should be a window of opportunity for healing, during which children live in nurturing, supportive, and stimulating environments that meet their needs. Even when foster or kinship placement is stable over time, children must cope with ongoing losses and the many uncertainties associated with such placement. Feelings of loss, rejection, and unworthiness are worsened if visitation with birth family is unpredictable, there is incompatibility in the foster or kinship home, or if there are disruptions in foster care placement.^{1,42-44} There are, unfortunately, many experiences and transitions in foster care that represent crises from the child's viewpoint, including poor-quality visitation, changes in school or child care, loss of friends, teasing or bullying by peers, separation from siblings, going into a respite placement, being freed for adoption,

or reentering foster care after reunification has occurred. In particular, unstable foster care placement can result in a significant increase in behavioral and emotional problems that, in turn, result in more transitions among foster care placements.⁴⁴

Despite legal mandates to expeditiously formulate a permanency plan, more than half of children remain in foster or kinship care for longer than a year,^{8,45} and 22% remain for >3 years, while child welfare professionals attempt to either reunite families or find a suitable and safe kinship or adoptive resource.⁸ Prolonged uncertainty and failed attempts at reunification or adoption can erode a child's sense of well-being. Concerns about time in care need to be balanced, however, against the child's needs for physical and emotional safety and evidence suggesting that stable foster care placement may be a positive and therapeutic intervention for some children.^{46,47}

The importance of a competent, caring, nurturing, stable foster or kinship parent in supporting and advocating for a child's health and well-being cannot be stressed enough. Significant improvements in a child's health status, development, intelligence, school attendance, and academic achievement have been noted consequent to foster care placement.^{48,49} Thus, for children who have suffered severe neglect and abuse, placement in foster or kinship care can be an important opportunity for intervention and healing. This is especially true for highly specialized treatment foster care in which children with serious emotional and/or behavioral health concerns are placed with highly trained caregivers. When birth parents remain unable to provide adequate and safe care despite diligent efforts at rehabilitation, including trauma treatment, every effort should be

made to find permanency with an appropriate adoptive or kinship resource in a timely manner.

Unfortunately, although rare, children also may be further victimized by abuse and/or neglect in foster homes. Although many foster homes provide good to excellent care for children and youth, some foster parents lack the skills, patience, and support necessary to care for children with childhood trauma and the resulting complex behavioral, medical, emotional, developmental, and psychosocial needs. Nor do they have access to the array of supports and services that would help them.

Pediatricians, in particular, must remain alert to signs of poor care/abuse/neglect in foster and kinship homes and report suspected concerns to child protective services and foster care caseworkers. Worrisome signs include poor weight gain, lack of warmth between the child and the foster parent, a caregiver who is overly rigid and speaks harshly to the child, frequent missed/canceled appointments, and failure to comply with health recommendations, in addition to the usual signs of child abuse or neglect. Thus, pediatric health visits are an opportunity to screen the child for signs of abuse and neglect, assess the quality of the parent-child relationship, and share concerns with the child's caseworker or the professional responsible for certifying the foster home.

OUTCOMES OF FOSTER CARE

Long-term outcomes of foster care have been inadequately studied. National data indicate that 59% of children return to a parent or relative, 11% age out of foster care, and 21% are adopted out of foster care.⁸ Prevalence studies on specific populations of foster care alumni who have aged out show high rates of clinically significant mental health problems (54%), chronic medical illness (30%), unemployment

(19%–37%), poverty (33% live at or below the poverty level), lack of health insurance (33%–50%), and homelessness within 1 year of emancipation (22%–36%).^{50–53} High school completion varies from 50% to 85% but may occur years after emancipation, with 25% of those who graduate doing so through completion of a graduate equivalency diploma.⁵⁴ Rates of postsecondary education are low (16%), and only 1.8% complete a bachelor's degree by 25 years of age.^{55,56} One study of young adults who lived in foster care during adolescence found a prevalence of posttraumatic stress disorder twice that of combat veterans.⁵² These prevalence studies of high-risk adult populations do not indicate "cause and effect," because they are not representative and do not account for other variables, such as preplacement childhood trauma, that may have led to poor outcomes. Rushton and Dance⁵⁷ conducted a small study on a group of children in Great Britain who were adopted out of care between 5 and 11 years of age. Although 49% of adoptive families were doing well, 23% of adoptions had disrupted, meaning the child was removed and returned to foster care. Predictors of disruption were rejection of the child by the birth parent, older age at adoption, and a larger number of placements or returns to birth family before adoptive placement.

HEALTH STATUS AT ENTRY TO FOSTER CARE

The complex trauma histories of children who enter foster care and their poor access to appropriate health care services compound their significant unmet health needs.^{1,41,58–62} In fact, limited health care access and unmet health needs may persist in foster care.^{3,43} Furthermore, children whose biological parents were investigated for suspected maltreatment and remained at home have similar rates

of physical, developmental, and mental health problems as children placed in foster or kinship care.³

Data from the past 30 years demonstrating the high prevalence of health problems has led the American Academy of Pediatrics (AAP) to classify children in foster care as a population of children with special health care needs.^{1,3,41,43,58,59,61,62} Childhood trauma and adversity underlie health issues, and the ongoing loss and uncertainty in foster care may exacerbate rather than ameliorate problems. Overall, 30% to 80% of children come into foster care with at least 1 physical health problem, with fully one-third having a chronic health condition.^{3,16,35,41} It is common for such problems to have gone undiagnosed and untreated before foster care. In addition, 46% to 60% of children younger than 6 years have a developmental disability that qualifies them for services. Up to 80% of children in foster care enter with a significant mental health need,^{1,3,41,43} and 20% have significant dental issues (Table 1).

Understanding the role of childhood trauma in the emergence of child mental health problems is extremely important, because it will direct the child toward appropriate treatment.

TABLE 1 Health Problems at Entry to Foster Care⁴¹

Problem or Condition	%
Chronic or untreated physical health condition	35–45
Birth defect	15
Mental health problem	40–95
Developmental/educational:	
Developmental delay in child <5 y	60
Special education placement/academic underachievement	45
Significant dental conditions ^a	20
Family problems ^b	100
Reproductive health issue risks (eg, pregnancy and sexually transmitted infections)	100

^a Data are from Starlight Pediatrics, personal communication. Sangeeta Gajendra, DDS, MPH, Eastman School of Dentistry, Clinical Chief of Community Dentistry, Rochester NY, 2002.

^b By definition, because that is why they are in foster care.

Pediatricians may need assistance from mental health professionals trained in trauma-informed care to correctly diagnose children.⁶³⁻⁶⁵ In the primary care setting, the pediatrician can administer a validated mental health screening as an initial assessment,⁶⁵ but the consensus among experts in foster care health calls for a mental health evaluation within 30 days of placement, ideally by a child mental health professional trained in trauma-informed care.⁶² Periodic reassessment of mental health should occur whether the child is in receipt of mental health services (see Recommendations) because of the many uncertainties and transitions that can occur. Children should receive recommended mental health services consistent with their diagnoses. Trauma-informed, evidence-based therapies, such as parent-child interaction therapy, child-parent psychotherapy, and trauma-focused cognitive behavioral therapy, have been shown to be effective in the management of childhood trauma symptoms.⁶⁵⁻⁶⁷ Unfortunately, there is a shortage of mental health professionals with the appropriate training in trauma-focused therapies, and funding is insufficient to ensure that all children who might benefit from these interventions can access them. The shortage of mental health professionals, coupled with the high prevalence of mental health conditions in this population, calls for strong collaboration between pediatricians and mental health partners, including psychiatrists, psychologists, and developmental and behavioral pediatricians, among others.⁶⁴ One promising model for the care of children in foster care is integrated pediatric and mental health care services in the pediatric medical home setting. Training in childhood trauma for caseworkers and foster parents has improved in recent years, and ongoing support for foster parents by well-educated professionals is important. The National Child Traumatic Stress Network has

a specific training for foster caregivers around parenting the traumatized child.⁶⁶

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 Medicaid-enrolled children and have higher rates of polypharmacy.⁶⁸ Once psychotropic medications are prescribed, children in foster care are likely to be kept on them longer than other Medicaid-enrolled children who are not in foster care.⁶⁹⁻⁷¹ Factors that may contribute to the apparent overtreatment with psychotropic medications include caregiver demand for medication to manage disruptive behaviors, lack of understanding of childhood trauma, lack of pediatric mental health resources, and misdiagnosis of trauma symptoms as other mental health conditions, such as attention-deficit/hyperactivity disorder.⁷²

The use of psychotropic medication is appropriate for some children in foster care with specific mental health diagnoses. Conditions, such as depression and anxiety, diagnosed after a full mental health evaluation and trauma assessment, respond to treatment with indicated psychotropic medications. Some pediatricians also choose psychotropic medications as a short-term, temporizing measure to manage severe sleep problems or emotional distress symptoms or when foster care placement is at risk, pending the availability of mental health services and foster parent education around appropriate parenting strategies.⁷³ Children who have experienced trauma, especially those who have lacked appropriate caregiving and treatment, may develop depression over time^{74,75} or may have comorbid

mental health problems for which psychotropic medication prescription is appropriate treatment.^{72,76,77} At least 1 study indicates that adult depression in those with a history of childhood trauma is more responsive to psychotherapy alone or in combination with medication than to pharmacological treatment alone.⁷⁸

There is concern that treatment with psychotropic medications may not address the underlying trauma and attachment issues at the root of challenging behaviors.⁷⁹ Concern over this question, coupled with the fact that most psychotropic medication prescriptions for children constitute off-label use, prompted Congress to require states to monitor and oversee the prescribing of psychotropic medications to children in foster care in 2 recent pieces of legislation (the Fostering Connections Act of 2008 [Pub L No. 110-351] and the Child and Family Services Improvement and Innovation Act of 2011 [Pub L No. 112-34]). Most states now require written consent by the legal guardian, court, or authorized person at the child welfare agency before psychotropic medications can be prescribed for a child in foster care.

Guidelines for psychotropic medication use in the foster care population have been published.⁸⁰ Ideally, psychotropic medications are prescribed only for children in foster care after a mental health evaluation and trauma assessment by a child mental health expert and for a specific mental health diagnosis. Psychotropic medication use should be but one part of the mental health treatment plan, and children should receive other recommended mental health interventions. The medication should be appropriate to the diagnosis, initiated at the lowest appropriate dose, and increased slowly while monitoring for efficacy and adverse effects. Polypharmacy should be avoided whenever possible, and 2 drugs from the same class

should not be used simultaneously. Ideally, all the child's caregivers are involved in the mental health treatment plan when appropriate.

ADOLESCENTS IN FOSTER CARE

Adolescents in foster care are at high risk of having untreated mental health; medical, educational, and reproductive health; and psychosocial problems.^{81–83} Even though many are in foster care for behavioral issues, including school truancy, staying away from home overnight, petty criminal activity, or other ungovernable behaviors, most have, in fact, endured neglect or emotional, physical, and/or sexual abuse at some point in their lives. Some enter care as adolescents, but others have grown up in foster care; many have or will experience multiple foster care placements, including placements in residential and group homes, juvenile justice settings, and inpatient psychiatric or drug rehabilitation settings.

Approximately half of youth in foster care have chronic medical problems unrelated to behavioral concerns.⁸⁴ Youth in foster care engage in more risk-taking behaviors than non-foster care youth.⁸⁵ By age 18, 93% of youth in foster care report being sexually active and almost half of these youth report sexual initiation before the age of 16. Compared with peers not in foster care, foster care youth are approximately 2.5 times more likely to experience a pregnancy by age 19.^{86–88} Nearly half of female youth transitioning out of foster care have experienced a pregnancy before age 20, well above the national average of 31%.⁸⁹ Youth in foster care are more likely than youth not in foster care to report unintended pregnancy and less likely to use regular contraception.⁹⁰ Repeat pregnancies among youth in foster care occur in almost half of all young women, compared with less than one-third of their peers not in foster care. Compared with other youth, young

adults in foster care are almost twice as likely to have experienced forced sex.⁹¹ Youth in foster care experience substantial health issues, as well as issues transitioning from adolescence to adulthood. Youth in foster care also have higher rates of unemployment, poverty, and homelessness than youth not in foster care.

Adolescents entering foster care report high rates of violence exposure and weapon carrying for purposes of self-defense. They often report having few/no friends or choose to associate with peers who engage in high-risk behaviors. Substance abuse rates are high. School attendance has often been interrupted, resulting in high rates of school failure and low literacy levels. Many teenagers in foster care lack exposure to normalizing activities because of limited funding, transportation barriers, mobility among placements, consent barriers, lack of signed health forms, and scheduling conflicts among mental health visits, work, and visitation with family. Adolescents who have positive peer relationships and adult mentors seem to fare better.^{57,92,93}

BARRIERS TO RECEIPT OF ADEQUATE HEALTH CARE IN FOSTER CARE

Pediatricians often face significant barriers in providing appropriate health care services to children in foster care. The health care of this population is time-consuming and challenging, and care coordination is particularly difficult because of the transient nature of the population and the diffusion of authority among parents, child welfare professionals, and the courts and requires at least some coordination across disciplines.^{1,41,43,94} The health care children receive while in foster care is often compromised by lack of health information; consent and confidentiality barriers; insufficient funding; poor care coordination; prolonged waits for community-based medical, dental, and mental

health services; and poor communication among pediatricians, child welfare professionals, parents, and legal professionals.^{1,41,43,94} Receipt of health care is often on a crisis-oriented basis, rather than planned, preventive, and palliative. Lack of health information at the time of placement coupled with complicated physical, mental health, and developmental conditions and complex social dynamics makes the care of this population challenging, even for the committed pediatrician. Foster parents and caseworkers may not 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.⁵⁹ Pediatricians may be unfamiliar with the structure of child welfare, its regulations and mandates, and how to coordinate health care across disciplines in a way that improves health access and outcomes for these children. Caring for adolescents in foster care is further complicated when child welfare regulations and mature minor or public health laws appear to contradict each other.

Lack of Health Information

The child's health history is often unavailable or incomplete at the time of placement in foster care. Birth parents may be absent or uncooperative, and caseworkers may be unable to elicit information from them. Before removal from their home of origin, children may have had multiple previous health providers or limited contact with the health care system. Caseworkers and/or pediatricians may have to contact schools, child care providers, and former health care providers, if known, to obtain health information. Additional sources of immunization information include the community immunization registry or the immunization program at the local health department. In the absence of parental consent, the local or state child welfare commissioner or his or

her designee has the authority to consent for the sharing of health information, unless the child has been placed in foster care voluntarily. In addition to immunization records, it is important to document newborn health screening results; any record of hospitalizations, surgeries, allergies, chronic illness, medications, and vision or hearing loss; and family history, when available. Developmental or educational evaluations, if they have been performed, may be available from Early Intervention, Head Start, and/or the child's home school district.

Consent and Confidentiality Barriers

One of the most confusing aspects of caring for a child in foster care is identifying who has the authority to consent for health care on behalf of the child or adolescent and with whom health information should be or may be shared.⁶² Research shows that consent procedures vary widely among states.⁹⁵ Pediatricians are advised to familiarize themselves with the pertinent laws and regulations governing these issues in their own states and to consult with state and local authorities, including their legal teams, for clarification when needed.⁹⁶ The following represent general guidelines regarding consent for a child in foster care:

- In many states, the birth parent/legal guardian at the time of entry to care retains guardianship and, thus, the right to consent to treatment on behalf of the child.
- In many states, the commissioner/director of child welfare, or his or her designee, is the consenting party for children who are freed for adoption and residing in foster care, unless the court has designated a legal guardian. A court process is required to terminate parental rights or grant guardianship to another caregiver.
- Many agencies have parents/guardians sign a general medical

consent at or shortly after placement, which covers most routine care. Special situations, such as prescription of psychotropic medications, mental health evaluations, surgery, and chemotherapy, are not considered routine care in most states and would require separate specific informed consent. A copy of the general medical consent for health care may be obtained from the child welfare caseworker or foster care agency office and maintained as part of the child's health record.

- In most states, foster parents have physical custody of the child but do not have the legal authority to provide consent for health care, except where the court has granted consent rights or through guardianship. Those with guardianship should have a court-issued document indicating this.
- In situations in which the birth parent/guardian is uncooperative or unable to provide consent, the child welfare commissioner/director or his or her designee has the authority to provide consent after diligent effort has been made to engage the parent/guardian. Specific time frames and what constitutes diligent effort vary among states. In some states, child welfare has to petition the courts for consent.
- The commissioner may not sign for Early Intervention evaluation or services, but the court may appoint an educational surrogate when the birth parent is unavailable or fails to act in the child's best interest.
- Depending on the health issue, the child welfare commissioner/director or his or her designee may request written documentation from pediatricians or pediatric subspecialists before granting consent for specific interventions.
- Immunization administration is usually covered in the general medical consent or in state foster care regulations for this population.

A Vaccine Information Statement should be given to the adult who accompanies the child to the visit and a notation made in the child's medical records. Foster parents do not have the right to refuse immunizations for a child in foster care.*

- If a child in foster care presents with an emergency medical or mental health problem and no consenting party is available, the physician may render appropriate medical care without signed consent.
- Local health or child welfare authorities should be able to address applicable regulations and legislation regarding consent for HIV screening in the foster care population. Some states address this issue on their HIV consent forms. Adolescents desiring confidential testing may be directed to confidential state HIV screening/testing sites in some states.
- Adolescents in foster care with capacity to consent may consent for reproductive health care, family planning, and specific other health concerns, including mental health, substance use and abortion, although laws and age of consent vary among states.⁹⁵ Youth 18 years and older with capacity to consent should be treated as adults. Youth 18 years and older without capacity to consent should have a legal guardian with whom the pediatrician communicates.
- Some states have specific consent procedures related to the administration of psychotropic medications to children and adolescents in foster care, and some states require written informed consent before the administration of these medications to a child in foster care.

*Use of blanket consents for immunizations may not satisfy the Vaccine Injury Compensation Program requirements for distributing the Vaccine Information Statement to the patient's legal representative before administering the vaccine.

Confidentiality is an important but often burdensome issue in caring for children in foster care. Once again, it is essential that pediatricians understand the guidelines in their own state. Foster parents and caseworkers, in general, have access to all health information regarding children and teenagers in foster care. Exceptions in some states include information related to substance abuse, sexually transmitted infections, birth control, abortion, and other reproductive health issues. HIV-related information is handled differently by different states. Because pediatricians may be called on to address any of these issues, screen patients for HIV, or interpret results for families and caseworkers, it is essential that they have some familiarity with the bounds of confidentiality for children and adolescents in foster care in their state.

Financing May Not Align With the Goals for Health Care and Outcomes

Medicaid, which funds health care for nearly all children in foster care, should, but fails to, cover the intensity and complexity of services and care coordination (eg, obtaining consents, locating health histories and immunization records, referrals, team meetings, caregiver education) these children require.^{61,62,97,98} Research has demonstrated that children with Medicaid face longer wait times and difficulty scheduling appointments with specialty care providers.⁹⁹ But the larger issue of inadequate or delayed payment limits access to health services. Across the country, medical home models that provide comprehensive health services and care coordination for children in foster care rely on other funding sources besides Medicaid payment to remain viable. Such sources include grant funding, contracts with local child welfare agencies, local public health dollars, and Medicaid-Targeted Case Management funding (although controversy exists about

whether children in foster care are eligible for the latter because they have a child welfare case manager).¹⁰⁰

Meanwhile, children in foster care expend a high proportion of Medicaid dollars but remain in overall poor health. A recent review of health care utilization patterns by children in foster care in New York showed that this population had low receipt of preventive health services, whereas utilization of more expensive services (inpatient medical, inpatient psychiatric, and emergency department care for mental health and medical care) was extremely high compared with other Medicaid-insured children.¹⁰¹ Many children still lack access to the very services that they need. Wisconsin is, in fact, the first state to receive approval from the Centers for Medicare and Medicaid Services to provide an enhanced benefit package of Medicaid-funded health services to children in foster care in 6 counties¹⁰² in a joint effort with Children's Hospital of Wisconsin.

The Affordable Care Act offers some hope. The opportunity for states to use Medicaid dollars to create Health Homes, which are essentially Medicaid-funded care coordination services for children and adults with chronic conditions, including mental health and substance use disorders, is one example. Only a handful of states have opted into the Health Home model, but it offers states and localities the opportunity to create well-coordinated networks of care for those with complex health issues. Another key benefit of the Affordable Care Act for children in foster care is the mandate that, beginning in 2014, youth who age out of foster care at 18 years or older remain eligible for Medicaid coverage until they reach 26 years of age.¹⁰³

Many states are mandating that children and adolescents in foster care be enrolled in Medicaid managed

care (MMC) plans.⁶² Concerns about MMC plans include rationing of services, especially mental health services, and the challenges of continuing coverage when a child moves among foster care placements and outside the coverage area of a current MMC plan. In negotiating with MMC plans, child welfare organizations should work with pediatric experts to ensure that benefit packages are structured to include guidelines recommended by the AAP, the American Academy of Child and Adolescent Psychiatry, and the Child Welfare League of America. As Centers for Medicare and Medicaid Services seeks to reduce health care costs and improve the quality of care, pediatricians, public health officials, and child welfare agencies have an opportunity to collaborate around innovative payment strategies that better fund evidence-based trauma-informed and preventive health care services that may reduce the utilization of less effective and high-cost interventions.

Lack of Care Coordination and Communication

Coordination of health care for the individual child in foster care, whose health needs may be complex and intense, is extremely challenging. This is compounded by the lack of clear systems for communication among families, youth in care, and multiple professionals, including child welfare caseworkers, health and mental health care providers, legal professionals, early intervention providers, educators, and others involved in the care of the child. Communication is also impaired because of the lack of systems for information sharing and data management.^{62,104} As states move forward with implementing the Affordable Care Act and electronic health records, and with meeting legislative mandates around children in foster care, many are reevaluating and redesigning existing systems and processes with the potential to better

enable care coordination and communication. The rapid advances in the development of the personal health record portion of the electronic health record hold great possibilities for information sharing in this population. In fact, this highly mobile population should be prioritized for dissemination and implementation of the personal health record, because this would greatly help improve care coordination for these children and adolescents.

THE ROLE OF THE PEDIATRICIAN

As noted earlier in this report, most of the recommendations included in this technical report and the accompanying policy statement are based on the consensus of clinicians experienced in caring for children in foster care.

The Medical Home Model for the Child in Foster Care

The pediatrician has a special role in caring for children and adolescents in foster care. Ideally, a child or teenager in foster care retains a relationship with his or her former health care provider, but it is common for children and teenagers entering foster care to have had limited health access before placement or to have sought care from multiple providers.¹ A medical home for a child or teenager in foster care ideally offers high-quality, comprehensive, coordinated health care that is continuous over time, compassionate, culturally competent, trauma informed, family centered, and child focused^{104,105} (Table 2). This requires a special commitment on the part of the pediatrician because of the more intensive needs of this population, as well as the mandates and innate complexities of the child welfare system. Foster care is a unique microculture because of the effects of previous trauma, ongoing uncertainty, transitions, and losses on children, teenagers, and families. Physicians may find themselves

TABLE 2 Qualities of the Medical Home for the Child in Foster Care

Qualities of the pediatric medical home (http://www.medicalhomeinfo.org)
1. Accessible
2. Comprehensive health care
3. Compassionate care
4. Care that is continuous over time
5. Care that is coordinated
6. Culturally competent health care
7. Family focused
Additional features of foster care medical home
1. Competency in heightened surveillance for child abuse and neglect
2. Understanding of the effects of child abuse and neglect, childhood trauma, and removal from family on child, birth family, and foster/kinship family
3. Collaborative relationship with child welfare and legal system on behalf of child
4. Coordination of care with other community-based resources, including Early Intervention, mental and dental health professionals, Head Start, schools, child care providers
5. Team-based care that ideally would include a child welfare liaison, mental health expert, and health care monitoring manager
6. Mental health integration into the medical home or a referral network of trauma-informed mental health providers

providing care even when little or no specific information about the child is available at the time of the visit. However, assessing each child's unique needs at entry to care and beyond is critical. Establishing continuity of care and ensuring a trauma-informed comprehensive and coordinated treatment approach by all professionals involved should be one of the highest priorities for child welfare agencies and pediatricians.^{104,105} It is, in fact, now a federal recommendation that states develop systems of care for children in foster care (the Fostering Connections Act of 2008 [Pub L No. 110-351]).

Communication with all caregivers and professionals involved in the child's life is crucial to obtaining appropriate and timely services and to ensuring that child welfare integrates health planning into their permanency plan. The role of the caseworker as case manager is pivotal for the child during his or her time in foster care, and communication with

that individual should be frequent and open.

The expertise of the pediatrician lies in identifying physical, mental health, psychosocial, developmental, and oral health problems and assisting caseworkers and all caregivers in determining the types of additional evaluations, care, and community services the child requires. The pediatrician is a vital resource for the education of older children and teenagers about their own health needs and self-management. Pediatricians can facilitate care through good communication with caseworkers, foster parents, birth parents, adoptive parents, and the multiple professionals involved in the lives of these children. Children and adolescents in foster care, especially those with complex health needs, often lack an advocate with the health literacy skills necessary to negotiate the health system; the pediatrician can be an invaluable advocate or support under these circumstances.

Abuse or neglect may occur in a foster or kinship home, or a child may continue to be retraumatized during visitation, so the pediatrician will need to maintain surveillance for signs and symptoms of child abuse and neglect and have ready access to a consultant or referral center when needed. Pediatricians can play a critically important role in helping child welfare agencies, foster families, and birth families minimize the trauma of separation and uncertainty by reinforcing the need for positive parenting, predictable nurturance, normalizing activities, and the maintenance of similar routines and expectations across environments.

Through appropriate health care, referral, support, education, and a focus on a child's innate strengths and resilience, pediatricians can help to ensure that a child's time in foster care is a time for healing. A child or teenager who is healthier and whose caregivers feel supported and

empowered is less likely to disrupt out of a foster care placement and more likely to achieve permanency in a “forever family.”¹⁹

Best-Practice Models for Health Care Delivery

Across the country, a variety of best-practice health models have been developed to serve the foster care population.¹⁰⁶ One well-regarded model is the centralized medical home that both provides and coordinates health care and can be based at a university hospital, public health department, child welfare agency, or neighborhood health center. In some communities, child welfare agencies have been able to establish multidisciplinary teams with on-site health, developmental, educational, and mental health expertise to evaluate children entering foster care.⁵⁹ 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. Ongoing health care is then delegated to community-based pediatricians, but this requires oversight and monitoring. Currently, 3 states (IL, UT, and VT) have preferred-provider models for foster care, with centralized health care monitoring, a model in which health information around individual children is shared electronically with a team of health care managers at the state child welfare agency, where it is collated and tracked. Some counties (Philadelphia, PA; Baltimore City, MD) and states (UT, TX, NJ) have a health professional or team colocated with or readily available to child welfare professionals to assist with care management, whereas others delegate varying degrees of health care management to the pediatrician, especially when there is a specialized foster care medical home available in the community. In all models, health care coordination or management remains the ultimate

responsibility of the foster care agency, although best provided by a health care expert, and is fundamental to ensuring that the health needs of this complex population are met. For the child accustomed to transience, receiving health care in the context of a well-coordinated, high-functioning team of trauma-informed professionals can help with consistency and developing caring relationships.^{105,107,108}

Although the preceding represent the ideal models of health care for children in foster and kinship care, the vast majority of children receive their health care in community-based pediatric or family practice settings or in emergency departments. Even small steps toward coordination of care, tracking, and continuity can have a large effect on child health and well-being. Regardless of where a child receives care, health information needs to be incorporated into the child’s court-approved permanency plan to ensure that the child’s multiple needs are addressed. The health care management expert(s), caseworker, and/or pediatrician most likely will need to assist caregivers in arranging for all recommended evaluations and services for the child or adolescent in a timely manner.

The enrollment of children in foster care in MMC plans offers opportunities for improved tracking, care coordination, and quality improvement at the systems level. Health case management for individual children still needs in-depth, intensive attention to detail at the level of the individual health care manager, pediatrician, and caseworker. Furthermore, compassionate support, education, and training for foster and birth parents and for youth are ideally an integral part of the overall program of services provided to children and their families during and after placement.

The Pediatric Consultant to Child Welfare

As noted, recent legislation requires states to develop health care systems for children in foster care and to include pediatricians in the planning and development of those health care systems.¹¹ Pediatricians may serve as regional or statewide consultants to help develop their state’s health care coordination plan, including advising about policies and practices that will improve the quality and effectiveness of health services for this population.

RESOURCES

Participation and membership in the AAP Council on Foster Care, Adoption, and Kinship Care at the national level and in a similar committee at the local AAP chapter or district level may help pediatricians gain the resources and knowledge they need to provide optimal care and care coordination or to serve as a consultant at the systems level. The AAP has multiple resources available to pediatricians, including the Healthy Foster Care America Web site, AAP policy statements, and *Fostering Health* (see descriptions in the following paragraphs).

- The Healthy Foster Care America Web site (<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/default.aspx>) is a resource for pediatricians, child welfare professionals, foster parents, youth in foster care, judges, and attorneys. This site contains information on health issues common among children in foster care, a chapter action kit for AAP chapters interested in developing health and mental health resources for this population, and advice about parenting traumatized children through difficult transitions.^{106,108}
- For advocates and pediatricians seeking to understand more about the Fostering Connections Act and

its implementation across the country, the Web site http://www.nrcpfc.org/fostering_connections/index.html is an invaluable resource. The site offers plain-language explanations of the law's components as well as implementation resources for states.¹⁰⁹

- The National Council of Juvenile and Family Court Judges has developed a checklist¹¹⁰ to prompt judges to address important aspects of a child's health, and tools for judges.

Health Care Guidelines for Children and Adolescents in Foster Care

In 1988, the Child Welfare League of America, in consultation with the AAP, developed *Standards for Health Care Services for Children in Out-of-Home Care*.⁹³ This document still serves as the guideline for developing and organizing physical and mental health services for child welfare organizations. *Fostering Health: Health Care for Children and Adolescents in Foster Care*,⁶⁰ published in 2005 by the AAP, details practice parameters for primary health care, developmental and mental health assessment, child abuse and neglect screening, and health care management. This manual was designed as a reference for

medical, developmental, and mental health practitioners, as well as child welfare professionals. The manual is now available on the Healthy Foster Care America Web site (<http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx>) and pediatricians can use this information to assist child welfare administrators in developing systems of care for children in foster care and improving the care of individual children.

In general, health care guidelines for children in foster care adhere to certain fundamental principles. Children should receive health care in the context of a pediatric medical home, ideally one in which pediatricians have some knowledge and experience with childhood trauma and its effects. Children should be seen "early and often" after entry into foster care. The transition period around entry into foster care is one of great emotional turmoil for children, as they deal with the loss of all that is familiar and adjust to new relationships and living in a new environment. Children may bring with them challenging but previously adaptive behaviors that present great difficulties in the new environment or may be so distressed during this

period that the stability of the foster care placement is jeopardized. The flexibility and responsiveness of caregivers can determine whether foster care becomes a healing and therapeutic placement for children and adolescents or reinforces their experience that the world is a dangerous and unpredictable place. Thus, the guidelines state that children and adolescents have at least 3 health visits over the first 3 months in foster care so that pediatricians can familiarize themselves with the needs of their patients, support both children and foster parents through this transitional period, and assess the compatibility of children and foster parents (Tables 3, 4, 5, and 6). In addition, all children and adolescents would benefit from comprehensive medical, developmental, mental health, and educational assessments early in placement to identify all of their health needs, with health care provided in as comfortable and calm a setting as possible.

Children remaining in foster care beyond the first 90 days, as children with special health care needs, may benefit from more frequent health care assessments (Table 7). Additionally, the many transitions endemic to foster care, including

TABLE 3 Initial Health Screening Visit

Health Visit Type	Time After Entry to Foster/Kinship Care	Purpose	Components	Actions
Initial health screening visit	Within 72 h ^a	<ol style="list-style-type: none"> 1. Identify health conditions requiring prompt attention: acute/chronic illness, child abuse/neglect, mental health disturbance, pregnancy 2. Identify health conditions important in making placement decisions 3. Identify significant behavior issues important in making placement decisions 	<ol style="list-style-type: none"> 1. Review of health information 2. Review of trauma history 3. Review of systems 4. Symptom-targeted examination 5. Child abuse screen: growth parameters, vitals, skin, joints/extremities, external genitalia 6. Developmental surveillance or screen 7. Mental health screen: suicidality, homicidality, violent behaviors, trauma exposures 8. Adolescent health screen: pregnancy screen for sexually mature girls and sexually transmitted infection testing for all adolescents 	<ol style="list-style-type: none"> 1. Appropriate treatment and referral 2. Communication with caseworker 3. Anticipatory guidance related to transition into foster care, parenting the traumatized child, specific health issues

^a Some children should have their initial health screen within 24 hours: children younger than 3 years; any child with a complex chronic health condition or significant developmental delays, or on medication, or with an acute illness or infestation; any child with known mental health or behavioral problems; or any child for whom a more immediate examination for suspected child abuse and neglect is indicated.

TABLE 4 Comprehensive Health Assessment

Health Visit Type	Time After Entry to Foster/Kinship Care	Purpose	Components	Actions
Comprehensive health assessment	Within 30 d	<ol style="list-style-type: none"> 1. Review available health information 2. Identify acute and chronic health conditions 3. Identify developmental and mental health conditions 4. Trauma assessment 5. Develop an individualized treatment plan 	<ol style="list-style-type: none"> 1. Review of available health information including trauma history 2. Review of systems 3. Complete physical examination 4. Child abuse and neglect screen (See Table 3) 5. Family planning and sexual safety counseling for adolescents 6. Developmental screen and referral for evaluation 7. Mental health screen and referral for evaluation 8. Adolescent health survey 9. Review of school performance 10. Immunization review 11. Dental screen and referral 12. Hearing and vision screening 13. HIV risk assessment 14. Laboratory studies^a 15. Anticipatory guidance^a 	<ol style="list-style-type: none"> 1. Appropriate treatment and referral (mental health, developmental, educational, dental) 2. Communication with caseworker 3. Anticipatory guidance particularly around parenting traumatized child 4. Schedule follow-up visit

^a See recommendations in text.

inconsistent visitation, rejecting behavior by a parent, acceleration of a parent’s mental health issues, false promises by parents, incarceration of a parent, separation or reunion of siblings, court hearings in which permanency decisions are made, conflict between foster and birth parents, and being freed for adoption, can compromise children’s overall health, especially their emotional and developmental well-being. Thus, more frequent monitoring and reassessment of children’s medical,

developmental, educational, and emotional health and well-being may provide opportunities to educate and support caregivers and children. Pediatricians, because of their expertise in family relationships and child development, are in a unique position to assess the compatibility of the child and foster caregiver and to screen for child abuse and neglect or retraumatization. At the end of each health encounter, the pediatrician, in addition to rendering all appropriate treatment, can offer appropriate

trauma-informed anticipatory guidance,¹¹¹ make referrals, and communicate health information to the caseworker. The caseworker, in turn, is responsible for keeping the birth parent informed in the likely event the birth parent is not present at health visits.

Clinical Practice and Professional Readiness

The foster care–friendly practice/medical home is ideally a trauma-informed practice that recognizes that

TABLE 5 Follow-up to Comprehensive Health Assessment

Health Visit Type	Time After Entry to Foster/Kinship Care	Purpose	Components	Actions
Follow-up health assessment	Within 90 d	<ol style="list-style-type: none"> 1. Identify acute and chronic health conditions 2. Assess for ongoing stressors 3. Assess “goodness of fit” in home/monitor for abuse and neglect 4. Update immunizations 5. Provide health education 6. Review findings from developmental and mental health evaluations 7. Assess school adaptation and performance 8. Update and reinforce treatment plan 	<ol style="list-style-type: none"> 1. Physical examination as indicated: weight check imperative <3 y; child abuse and neglect screen 2. Observation of parent-child interaction 3. Foster parent/patient education^a 4. Immunization update 5. Review of referrals/reports 6. Review of treatment plan 	<ol style="list-style-type: none"> 1. Appropriate treatment and referral 2. Anticipatory guidance especially around parenting traumatized child 3. Communication with caseworker 4. Schedule follow-up appointment

^a See text for details.

TABLE 6 Periodic Primary Preventive Health Care: Modifications for Foster Care

Health Visit Type	Time After Entry to Foster/Kinship Care	Purpose	Components	Actions
Additional foster care related	See Table 7	<ol style="list-style-type: none"> Promote wellness Identify significant medical, behavioral, emotional, developmental, and school problems Regularly assess success of visitation, foster care placement, and goodness of fit Monitor for abuse and neglect Provide age-appropriate anticipatory guidance^a 	<ol style="list-style-type: none"> AAP recommendations with particular attention to child abuse screen; growth, development/school function, emotional health, behavioral health, HIV risk assessment; pregnancy and sexually transmitted infection risk; parent-child "goodness of fit"; visitation/permanency plan; impact of any transitions; service needs and whether being met Immunizations Anticipatory guidance^a 	<ol style="list-style-type: none"> Appropriate treatment and referral Communication with caseworker Update treatment plan

^a See text for details.

foster care is a microculture in which children have experienced varying degrees of adversity and trauma that affect their health and well-being.⁷³ Practice readiness may include longer appointments for the initial screening; comprehensive and subsequent preventive health visits; providing health summaries and/or care plans to caregivers; having a system for communicating the health summary to the child's caseworker; keeping contact information for the state and county child welfare and local foster care agencies available; having contact information for the child's caseworker in the chart; validating children's feelings about coming to the doctor and being in foster care; asking the child what he or she calls his or her foster parents and using the same terminology; speaking with compassion about birth parents;

focusing on a child's strengths and assets; and teaching the child strategies for dealing with uncomfortable situations. Using pain-reduction techniques, such as bubbles, to "blow away the pain" while administering immunizations, can help traumatized children manage stressful situations. In the foster care-friendly office, pediatric staff would ideally have some training in trauma-informed care.⁷²

THE COMPONENTS OF HEALTH CARE SERVICES

Ideally, children and adolescents entering foster care are seen "early and often" during the transition phase (the first 3 to 4 months) to assess and monitor their health and well-being, their adjustment to the foster placement, visitation with birth parents, and the goodness of fit

between the child and the new caregiver. Even after this transition period, the child in foster care benefits from more frequent monitoring of his or her health status. The components of health care services are detailed in *Fostering Health: Health Care Standards for Children and Adolescents in Foster Care*, and what follows is a brief synopsis of those components (<http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx>).^{60,108}

THE ADMISSION HEALTH SERIES

Initial Health Screen

The current AAP health recommendation is that every child and adolescent entering foster care

TABLE 7 Recommended Health Care Visits for Children and Adolescents in Foster Care

Age of Child	Preventive Pediatric Health Care Visits ¹¹¹	Additional Recommended Monitoring Visits ⁶⁰
Birth–6 mo	2 wk; 2, 4, and 6 mo	Ideal to see monthly, especially if born preterm or has chronic medical problems
6–24 mo	9, 12, 15, 18, and 24 mo	21 mo of age to assess behavior and development
24 mo–21 y	Every 12 mo	Ideal to see at least every 6 mo to assess behavioral health and developmental and educational needs and monitor adjustment to foster care and visitation. Children with significant issues in any health area may need to be seen more frequently.

Reasons for additional visits for children and adolescents in foster care

- Foster parent support and education.
- Need for frequent monitoring for impact of transitions, visitation, and uncertainty, and ongoing adaptation to placement.
- Address emerging problems, especially behavioral, emotional, developmental, and educational.

have a health screening within 72 hours of removal (Table 3). Some children should have their initial health screen within 24 hours: children younger than 3 years; any child with a complex chronic health condition or significant developmental delays, on medication, or with an acute illness or infestation; any child with known mental health or behavioral problems; or any child for whom a more immediate examination for suspected child abuse and neglect is indicated. Occasionally, this initial health visit will occur before or at the time of placement. The purpose of this visit is to identify any urgent medical or mental health needs the child may have and any acute or chronic health conditions of which the foster parent and caseworker should be aware, especially if those conditions affect placement decisions. Child welfare caseworkers may occasionally consult pediatricians about the suitability of a proposed foster care placement, especially if the child has complex medical problems or a chronic health condition, such as asthma. Many localities have a few foster homes that specialize in providing care for children with complex medical illness, autism, or severe cognitive impairment. Ideally, children with asthma or other cardiorespiratory illness should not be placed in homes in which there will be exposure to tobacco smoke or other noxious fumes. Placement should be in a home that is safe for the child's age and stage of development. Ideally, children, especially those with cardiorespiratory or complex medical problems or younger than 2 years, should not be placed in homes in which adults or children in the home are underimmunized or unimmunized. Child welfare caseworkers should ideally consult with a pediatrician or the local health department about safety issues for individual children when such questions arise.

Screening for and documentation of child maltreatment is an important

component of this visit and includes careful measurement of height and weight for all children and head circumference for children younger than 3 years to assess for growth delays, poor nutritional status, and general health status. The measurement of head circumference up to age 3 years is based on the consensus of experts in foster care health and differs from the recommendation for the general population that recommends head circumference measurement for children younger than 2 years. Measuring head circumference up to age 3 years is advised because of multiple risk factors for abnormal brain growth, including prenatal drug exposure, neglect, and inflicted head trauma. Children in foster care also have a higher incidence of genetic diseases that may present with abnormal head growth.

Because many children entering foster care have been victims of physical or sexual abuse, all body surfaces should be examined in the process of a thorough physical examination by uncovering different body areas as the examination progresses. Any signs of recent or old trauma, including bruises, scars, burns, deformities, or limitations in joint mobility or impaired organ function should be noted and documented. The AAP recommends that suspicious findings be photographed. All documentation, including photographs, should include the child's name, birth date, and the date and time of documentation. 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 acute or healing fractures should be considered. Imaging studies of the head, abdomen, and skeleton may be necessary in children younger than 3 years for whom there are concerns about physical trauma. External genital and anal examination should be conducted for both genders by the

most experienced available pediatrician, ideally with some experience in child sexual abuse. The pediatrician may wish to consult a child abuse expert if there are any concerns about physical or sexual abuse. Laboratory tests should be performed for HIV and other sexually transmitted infections for all adolescents as well as for young children, when indicated clinically or by history. The pediatrician may elect to defer laboratory work until a later visit depending on the child's level of cooperation and distress.

Occasionally, a child is so traumatized that wisdom dictates deferring parts of the physical examination and any potentially painful procedures until the child establishes some rapport with the pediatrician. All communicable diseases should be noted and treated promptly. Adolescents with high-risk sexual behaviors may need immediate treatment of sexually transmitted infections. The status of any acute and chronic illnesses should be determined to ensure that appropriate medications and equipment are available and referrals are in place.

The initial health visit is an opportunity to review available health information, determine what information is missing, and discuss specific care instructions directly with the child's caregivers and caseworker, rather than through an intermediary. Brief developmental surveillance, including behavioral and emotional health, should be conducted for the child younger than 5 years, although the caregiver likely has limited knowledge about the child and the child may be in such emotional shock that developmental skills and emotional health may be challenging to accurately assess. Screening for acute mental health and behavioral issues, especially suicidal and homicidal ideation or a history of violent behaviors that might require urgent mental health assessment and management, is important in children

5 years and older so that appropriate care can be sought. The initial health visit is an opportunity for age-appropriate anticipatory guidance, including counseling around transition issues, positive parenting strategies, and the effects of childhood trauma.^{64–66,111,112}

Care coordination at this visit includes scheduling an appointment for the comprehensive health assessment and any other indicated follow-up, making needed referrals, and establishing communication with the child's caseworker. Initial referrals for mental health, developmental, and educational evaluation and dental care also may be made.

Comprehensive Health Assessment

The comprehensive health assessment (Table 4) occurs at or around 30 days after placement in foster care. The goals of the comprehensive health assessment include reviewing all available health information, identifying and treating all health conditions, assessing the child's adaptation to foster care and visitation with parents, and ensuring that developmental, educational, dental, and mental health evaluations are completed, under way, or scheduled.

Health Information Gathering

Child welfare agencies have a responsibility to make all pertinent health, developmental, psychosocial, and family history available to assist the pediatrician in performing the comprehensive health assessment. Ideally, this information is available at the time of the comprehensive health assessment, but in reality, information gathering begins at admission to foster care and is an ongoing process over time that may take months or never be completed. The child's foster parents and caseworker, if possible, should be present for health visits. When appropriate and safe, birth parents should be encouraged to participate

in health care visits and decisions. Ideally, health information should be obtained from both foster and birth parents as well as from the child, when developmentally appropriate. The pediatrician should spend at least a few minutes alone with the verbal child for purposes of obtaining confidential history. Assessing the child's feelings about the current placement setting is best done during this private conversation. The initial historical review should include the circumstances that led to placement, the child's adjustment to separation from the birth family, trauma history, adaptation to the foster home, developmental or school progress, visitation with the birth family, and the agency's plans for permanency. The goal of the permanency plan early in placement is usually "return to parent," although most agencies now engage in concurrent planning, for both reunification and an alternative permanency plan. As time passes, the permanency goal may evolve, depending on the cooperation and compliance of the birth family with meeting the safety and other needs of the child. Understanding the permanency plan is helpful in providing appropriate anticipatory guidance to children and caregivers. Alternate permanency plans may include placement with a relative, adoption, guardianship, state guardianship (for the significantly cognitively impaired), or independent living.

Physical Examination

A thorough and compassionate physical examination should focus on the presence of any acute or chronic medical conditions, signs of abuse and neglect, or emotional, behavioral, or developmental concerns that may require additional examination, evaluation, or referral. The provider should try to visualize all body surfaces during the course of the examination to monitor for signs of abuse and neglect in the foster home.

Immunizations

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 reviewing school, child care, and immunization registry records increases 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 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 protective or foster care caseworker or the commissioner of social services or to clarify the process that will need to be followed to allow for timely immunization. Foster parents do not have the right, under law, to refuse immunizations for children in foster care residing in their homes.

Screening

Children entering foster care are at high risk of having vertically transmitted infections, anemia, malnutrition, hearing and vision problems, and elevated blood lead concentrations, for which screening tests should be performed, according to the AAP Bright Futures guidelines.¹¹² Because weight loss is often the first sign of poor care in a foster home, growth parameters should be measured at each stage of the admission health series and at each periodic preventive health visit. Obesity is now the most prevalent form of malnutrition currently

encountered in foster care, although some children are still admitted with failure to thrive.¹¹³ The high prevalence of childhood neglect, prenatal drug exposure, malnutrition, and neurologic problems in this population make it important to measure head circumference in all children up to 3 years of age. Because children in foster care have a high prevalence of vision and hearing problems, all children should have age-appropriate vision and hearing screening at entry into foster care and at each periodic preventive health visit.³⁵ All new entrants to foster care are considered at high risk of having HIV infection, hepatitis B and C, and other sexually or vertically transmitted infections. Adolescent girls should receive a pregnancy test. Laboratory tests for lead exposure and iron deficiency should be performed in children younger than 6 years or any child with a history of pica or signs of inadequate nutrition. Children in foster care are at higher risk of tuberculosis exposure and should be screened with the placement of a purified protein derivative. Other screening that should be considered includes rapid plasma reagin test, urinalysis, and hemoglobin measurement in menstruating adolescent girls. All other laboratory evaluation should be problem focused or as per AAP guidelines. Invasive procedures, such as blood work, should be coordinated so as to minimize trauma in this population. All children should be referred for an oral health assessment.

Developmental, Educational, and Mental Health Evaluations

The comprehensive health assessment is an opportunity to perform developmental and emotional health screening if evaluation is not already completed or imminently scheduled. It is also an opportunity to conduct or refer a child or teenager for developmental, educational, and mental health evaluations if not in process.

Developmental and emotional screening in the primary care office is complicated by changes in caregivers, but foster parent report instruments should be reasonably accurate after 4 to 8 weeks in a new home. Validated developmental and mental health screening instruments can be useful in triaging children for further evaluation when resources are limited, although ideally, every child and teenager in foster care should eventually receive a mental health and developmental or educational evaluation conducted by an appropriately certified/licensed mental health professional. For younger children in foster care, developmental and behavioral conditions are best identified in the context of a full developmental evaluation. For children older than 5 years in foster care, emotional and behavioral conditions are best assessed by a pediatric mental health professional with training in childhood trauma. In addition, because school failure and learning issues are epidemic in foster care, an educational evaluation is helpful in identifying learning strengths and difficulties and determining appropriate school placement. Some children enter foster care with an individualized education plan or 504 plan through their school district to which the caseworker should have access. Local consultants and community-based intervention programs can assist in diagnosing and treating children with developmental and educational problems. Pediatricians also may assist social workers and foster parents by referring eligible children to various federal and state entitlement programs in their community (eg, Head Start, Early Head Start, Birth-to-Three, special education, and Early Intervention). In fact, children younger than 36 months who are in foster care because of child maltreatment are automatically eligible for an Early Intervention assessment under the

Child Abuse Prevention and Treatment Act (Pub L No. 111-320 [2010]).

Adolescents

Because of high rates of sexual activity, sexual abuse, or assault, all adolescents should be screened at entry and then at periodic preventive health visits, or whenever a concern arises, for sexually transmitted infections. All girls should be screened for pregnancy and counseled about pregnancy prevention. Safe, reliable birth control, ideally in the form of long-acting reversible contraception, should be made available. Counseling regarding reproductive health, sexual safety, and healthy relationships is of paramount importance for all teenagers in foster care, taking into account the consent/confidentiality issues for these youth. As for all adolescents, surveillance or screening for substance use disorders is advised.

Engendering a sense of self-efficacy and identity in a teenager whose life feels out of control and whose life has been riddled by chaos and violence is challenging.^{91,92,114} Pediatricians can help adolescents by listening and responding to the teenager's concerns, and encouraging age-appropriate activities, healthy lifestyle choices, connection with mentors, and an orientation toward the future. Youth can be encouraged to be aware of their health history, and be provided a health passport containing immunization records and a list of current medications. States should establish rules around the use of Personal Health Information portals of electronic health records for youth in foster care that would ensure adolescents private access to their health records.

Every health encounter is an opportunity for frank discussion of psychosocial stressors, symptoms of depression or anxiety, reproductive health, and personal safety.

Pediatricians can encourage caseworkers and foster parents to focus on a teenager's strengths, and to provide opportunities for enjoyable social activities or hobbies inside and outside of the family. Regardless of whether their permanency plan is independent living, return to parent, or adoption, adolescents need to acquire skills that are crucial to future independence (eg, part-time job, managing money, completing their education, driver education). Pediatricians, caseworkers, and foster parents can advocate for opportunities for youth in foster care to acquire the skills that they need for a healthy transition to adulthood. The Foster Care Independence Act passed by Congress (Pub L No. 106-169) in 1999 provided foster care agencies with limited funding to enhance such services, and the Fostering Connections Act (Pub L No. 110-351 [2008]) reinforced and expanded these provisions.

Anticipatory Guidance

One of the major goals of the comprehensive health assessment is to provide detailed, trauma-informed anticipatory guidance to caregivers and older children/adolescents and young adults in foster care. In addition to usual age-appropriate guidance, other major areas of concern needing specific attention are the emotional impact of trauma and loss and its effects on behavior and discipline, emotional safety and attachment, and transition issues. The AAP has 4 publications that may assist pediatricians in supporting the caregivers of children in foster care.^{60,64,65,111}

The Emotional Effects of Trauma and Loss

The emotional effects of trauma and loss on a child are dependent on the severity, frequency, chronicity, and nature of childhood trauma and adversity and the presence or absence of protective factors in the child's life, minimally including caring

adults, the child's temperament, and the age and developmental capacities of the child. A 1-time traumatic event while in the care of a nurturing adult is likely less stressful for a child than ongoing exposure to intrafamilial stressors, such as domestic violence while in the care of a parent impaired by drugs and alcohol. Children, as noted earlier, may have maladaptive behaviors that were helpful to them in their preplacement environment. Caregivers may not fully understand the negative effects of chronic significant stress on brain development and may need reminders that positive parenting strategies, such as time in, child-directed play, reading, family routines, gentle coaching, and "catching the child being good," among others, will promote a sense of trust and security in the child. For older children, caregivers should explain the house rules as well as their role as a foster parent and helper to their birth parent, offer the child some simple choices when possible, use a reward system, and focus on child strengths and on teaching the child skills for his or her lifetime. Attentive listening is helpful with all children and teenagers, as are sharing family meals and times spent together in wholesome family activities. Many children enter foster care with attachment issues, but studies have demonstrated that they can develop secure attachment patterns to foster parents over time.¹¹⁵ More recent literature indicates that even adolescents who remain insecurely attached to their birth parents can develop secure attachment to their foster parents.¹¹⁶ Time out, loss of privileges, or grounding should be used minimally, if at all, during the first few weeks of placement while a child or teenager finds his or her way in the new "family." The pediatrician will occasionally encounter foster parents who use overly harsh or rigid disciplinary methods, including yelling, prolonged time outs, food

withholding, or corporal punishment. These are likely to evoke extreme distress in children with a history of trauma and maltreatment. Corporal punishment is expressly forbidden in foster care settings, as it should be. Caregivers should be educated about and encouraged to use positive parenting strategies and discouraged from using harsher methods of discipline or threatening children with severe harm, abandonment, or removal, because these reinforce feelings of rejection and worthlessness.⁷²

Caregivers and caseworkers should be advised that negative behavior is often an outward expression of emotional distress for which the child may have minimal language. In addition, traumatized children with poor self-regulation skills can go into full "fight or flight" mode when confronted with an even minor stressor. They may display aggression, extreme rage, hyperactivity, or dissociative or freezing behaviors in response to even minor stressors. All such behaviors should result in consultation with the child's mental health professional.

Safety

In addition to the usual safety issues discussed under anticipatory guidance, the pediatrician should pay particular attention to "good touch and bad touch," "stranger danger," and "safe adults," because many children in foster care display indiscriminate friendliness toward adults. In addition, children may spend time in riskier environments during unsupervised visitation or after leaving foster care. Foster caregivers should closely monitor contact with other adults.

Emotional safety is at least as important as physical safety and often much harder to assess. Occasionally, a birth parent uses subliminal triggers during visitation to incite a child's behaviors. Professionals and

foster caregivers may inadvertently trigger trauma symptoms through simple, even mundane, words or gestures that have deeper meaning for a child. Children with severe, prolonged tantrums or aggressive behaviors may, in fact, be dealing with intrusive memories of past traumatic events.

Transitions

Foster caregivers need advice on issues specific to foster care, many of which involve transitions. Caseworkers, birth parents, and foster parents may need reminding to speak respectfully of each other in the child's presence and to maintain similar and appropriate expectations, structures, and routines across environments to minimize confusion for the child and promote successful visitation. Children do best when caregiving adults prepare them for visitation, when visits are part of a routine and predictable schedule, do not disrupt school or scheduled activities, and when they have some "reentry time" after visitation; for some children, this is quiet time, for others, it is active play. The transition to adoption, usually a very positive outcome of foster care, can be painful for the child who views this step as "losing" his family of origin and is even more difficult for the child whose siblings are not being adopted by the same family. Preparation of the child for adoption should include a chance for the child to build a memory book of his birth family and, in the event of a "closed" adoption, to say good-bye to them in a meaningful way. Enhanced mental health support for the child, the adoptive parent, and the birth parent may be necessary during this period of time. Families adopting children from their own extended family may need assistance in explaining the new legal and social relationships to the child. The child might need some language to explain his or her new situation to friends and classmates, especially if there is a change in name.

As already mentioned, emancipation from foster care for the adolescent is a particularly dangerous transition, if the adolescent is not rooted in either his or her extended birth family or foster family. As stated earlier, legislation now requires foster care agencies to offer more services to this vulnerable group than a decade ago. But emancipating adolescents remain at high risk of experiencing unemployment and dire poverty, becoming homeless within a year of discharge, or engaging in or being the victim of criminal activity. A high percentage of young women become pregnant within the first year after discharge from foster care. Pediatricians should, in addition to other recommended practices around contraception, actively educate adolescent patients about long-acting reversible contraception methods given their efficacy, safety, and ease of use.¹¹⁷ Pediatricians can listen to adolescent concerns about impending emancipation and offer anticipatory guidance around independent living skills, in addition to collaborating with local community organizations, child welfare agencies, and funders to develop programs to increase supports and ease the transition into adulthood.¹¹⁸

Referrals

In most states, children younger than 5 years are eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children simply by virtue of being in foster care.

Ideally, referral for mental health, developmental, and educational evaluations occurs at the time of the initial health screen or comprehensive admission health assessment. A child younger than 36 months who has a substantiated finding of child abuse or neglect as a result of child protective services investigation is automatically eligible for an Early Intervention evaluation under federal law.

Other public benefits or programs for which some children/youth in foster

care are eligible include Early Head Start, Head Start, Supplemental Security Income (but usually these funds are directed to the agency to offset the board payment for the child), and Educational and Training Vouchers, which can provide up to \$5000 per year for college expenses for eligible foster care youth or alumni.¹¹⁹

Referrals for subspecialty care should not be delayed because of concern that the child may be discharged between the time of referral and the appointment date, because this may lead to extensive delays in care. Thus, the best time to make a referral is when a health issue is identified.

Follow-up to Comprehensive Health Assessment

Frequent health visits may benefit children and families during the first several months of foster care, a period of emotional turmoil and adjustment for children and teenagers as well as their caregivers. The 30- to 60-day follow-up after the comprehensive health assessment (Table 5) is an opportunity for the pediatrician to identify health issues that have come to light during this interval; review any additional health history that has emerged; update immunizations; review findings from the developmental, educational, and mental health evaluations; review and revise the treatment plan; monitor the "goodness of fit" between the child and foster caregiver; review pertinent anticipatory guidance; assess the child's overall adjustment to foster care; and determine an appropriate interval for the next health encounter. A weight check is imperative for children younger than 3 years, as is monitoring for abuse and neglect. Some triggers for more frequent health visits for purposes of monitoring and prevention include the presence of a chronic physical, mental, behavioral, or developmental health issue, ongoing prescription medication use, placement

instability, and frequent emergency department visits. Physically well children older than 2 years might need to be seen only every 6 months, as long as there is appropriate mental health care and no medical, developmental, educational, or behavioral issue requiring closer follow-up.

PEDIATRIC PREVENTIVE HEALTH CARE AND MONITORING OF HEALTH STATUS WHILE IN FOSTER CARE

As noted previously, foster care is fraught with transitions and challenges for children, teenagers, and caregivers. Events, even predictable ones, can upend the emotional well-being of children and adolescents and even caregivers. Problems that were not apparent at the outset often emerge during the course of placement. Even a minor change, such as scheduling of a court date or case review by child welfare professionals, may be sufficiently upsetting to cause deterioration in a child's behaviors, overwhelming a foster parent's coping abilities. More extreme emotional distress may occur around visits with birth family or at times of transition, such as a change in placement or separation of siblings. Children and teenagers often experience conflicting loyalties, worry excessively about their birth parent's well-being, or feel guilty for the disruption of their family. Some transitions in foster care may cause flares in physical health problems, such as asthma. Therefore, in addition to providing ongoing preventive primary health care, additional visits to monitor physical, developmental, and emotional health and psychosocial wellness may be needed. Any change in the well-being of children or their families should lead to consideration of additional services and interventions. At a minimum, infants may need to be seen monthly during the first 6 months of life, then every 3 months between the ages 6 and 24 months, whereas children and adolescents may need to be seen

every 6 months from age 2 years through adolescence (Table 7). Most of these visits will overlap the Bright Futures schedule for primary preventive health care visits, but may be in excess of some states' early periodic screening, diagnosis, and treatment schedules. Table 6 lists some of the important additions to preventive health or other periodic monitoring visits for children in foster care.

FOSTER CARE–SPECIFIC VISITS

Foster care–specific visits are usually related to transitions into or out of foster care, among placement settings, or around visitation with birth parents when caregiver conflict or concerns occur regarding child health or safety during visits or in the foster home. Extra health or mental health visits may be necessary during transitions, especially around changes in placement (foster home transfers, approaching reunification, being freed for adoption, nearing adoption, and aging out of foster care). A list of helpful payment codes is available on the Healthy Foster Care America Web site (http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Coding_Facts.pdf).^{60,107}

HEALTH CARE MANAGEMENT

Health care management is crucial but challenging in caring for a transitory, medically complex pediatric population with multiple caregivers and professionals involved. Communication, education, advocacy, and timely attention to multiple details are the essence of ensuring that the health care needs of children and teenagers in foster care are met. Recognizing that children and adolescents in foster care have multiple unmet health needs, Congress enacted the Fostering Connections Act, specifically requiring states to develop health care systems to

manage the health care of children in foster care. Most states have made some, but not substantial, progress toward this.

Health care management is ultimately the responsibility of the child welfare agency but requires a structure apart from traditional casework as well as the expertise of health professionals. Health care management at the level of the individual child is intensive, especially during times of transition. The functions of health care management include information gathering, organization, and maintenance; communication with appropriate parties; ensuring appropriate health consents are in place; health care coordination to ensure care is rendered so each and every child's needs are met; ensuring compliance with health care recommendations; monitoring foster parent compliance; educating the child's caregivers and other professionals and the older child/adolescent about health conditions and care; and ensuring that the health care plan is integrated into the child welfare permanency plan and court decisions. Web-based health records or use of the patient portal in the electronic health record, in particular, have incredible potential to decrease the health information gap among professionals caring for children and adolescents in foster care. Tiered access can be built into such systems so that information is accessible depending on the professional's role in the care of the child or teenager. If the child changes foster homes or returns to his or her birth family, a Web-based record has the additional advantage of being available to the new caseworkers, pediatricians, and caregivers.

States are also required to develop health-management systems at the population level for children and adolescents in foster care. Issues overseen at the state level include the content of consent forms and who may sign consent, insurance benefits,

insurance enrollment and disenrollment rules, who has access to health information, how health information will be communicated, the development of referral networks, quality assurance and improvement, and data aggregation and management. Some states have developed sophisticated health-management teams staffed with nurses and managed by a physician to gather, collate, and communicate health information.

SUMMARY

Children and adolescents involved with the child welfare system, especially those who are removed from their homes of origin and placed in out-of-home care, may present with complex and serious physical, mental health, developmental, and oral health problems rooted in childhood adversity and trauma. As children and adolescents with special health care needs, they require more intensive pediatric, mental health, developmental, and educational services. There are many barriers to providing high-quality comprehensive health care services to the transient population of children and adolescents in foster care, whose lives are characterized by adversity, loss, and uncertainty. Pediatricians have a critical role in ensuring that children and adolescents in out-of-home care receive high-quality pediatric health services that are comprehensive, compassionate, culturally sensitive, coordinated, and specific to their overall health needs. Pediatricians also have a role in health care coordination and advocacy on behalf of this vulnerable population.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ASFA: Adoption and Safe Families Act
MMC: Medicaid managed care

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