

Child Protection Accountability Commission (CPAC) and
Child Death, Near Death and Stillbirth Commission (CDNDSC)
Joint Foster Care Medical Committee Report
Safety, Permanency, Health and Well-being
January 2015

Vision Statement: To improve the well-being of children in foster care in Delaware by creating a medical standard of care for Delaware’s foster care system that reflects the American Academy of Pediatrics’ standards.

Mission Statement: To create a multi-agency committee to reduce the system barriers and uphold the American Academy of Pediatrics’ standards of care for children in foster care by a comprehensive assessment of Delaware’s current standard and practice of care through the evaluation of health care delivery, complex health issues, and electronic information sharing with the goal of proposing recommendations to improve the well-being of Delaware’s at-risk foster care children.

The American Academy of Pediatrics has published standards for health care for children and teens in foster care. The standards were designed to help professionals from all disciplines understand the complexity of health issues children in foster care may present with and emphasizes the need for coordinated and collaborative care. Fundamental principles such as being seen early, being seen often, and having an enhanced health care schedule are critical for a child’s health and success. As defined by the Maternal and Child Health Bureau and accepted by the American Academy of Pediatrics (AAP), “children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.” Children living in foster care have special health care needs.

In October 2008, due to efforts on the part of the American Academy of Pediatrics and other organizations advocating on behalf of children in the foster care and adoption systems across the country, HR 6398 was signed thus establishing the Fostering Connections to Success and Increasing Adoptions Act. The law, Public Law 110-351, is a comprehensive measure designed to improve outcomes, an aspect of which is meant to enhance health care for children in foster care through state’s developing plans, in consultation with pediatricians and other experts in health care and in the oversight and coordination of health care services, for children in foster care. Section 205 of the law requires states to develop a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement. The plan must ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs, and must include: a schedule for initial and follow-up health screenings that meet reasonable standards, how health needs identified through screenings will be monitored and treated, how medical information will be updated and shared, steps to ensure continuity of health care services, oversight of prescription medicines, and how the state actively consults with physicians and other professional in assessing the health and well-being of children in foster care and in determining the appropriate medical treatment for them.

This Committee’s initial case review project was an attempt to establish a baseline of how the current health care delivery stands. Improvements were made to the delivery of health care during the case review process. The review was time-consuming, so progress during this time frame is not surprising. However, system issues likely still remain and the establishment of a continual improvement process could prove beneficial to children’s long-term health and well-being.

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Project – Case Reviews

Process:

Took 10 randomly selected cases in each of the 4 regions for DFS (Division of Family Services): 2 in New Castle County, 1 in Kent County and 1 in Sussex County. Case was defined as a child in foster care at the time of the random selection, performed by DFS staff. Each case's documentation of medical information was reviewed by 2 unique individuals. The documentation of medical and health related information was found in hard copy (binder) or in FACTS (Family and Child Tracking System). Individuals who performed reviews included a pediatrician, DFS workers, CDNDSC (Child Death, Near Death, and Stillbirth Commission) staff and OCA (Office of the Child Advocate) staff. Individuals were trained alone or in a small group setting on the use of the data collection tool.

The data collection stage took much longer than expected due to difficulty in finding the data, documentation inconsistencies (FACTS versus hard copy), the hard copy needed to be reviewed on site and staffing issues. As noted in our update to the Joint Commissions in November 2012, another rate limiting step was the consolidation and organization of the data. Data collection began in summer 2010 and data collection completed in spring 2012.

Results of Case Reviews:

1. Demographics: Mean age of cases was 7 years 8 months of age (+/- 0.5 months). The ages range from 3 days to 16 years and 9 months. In New Castle County, the mean age was 7 years 11 months, in Kent County 9 years 11 months, and in Sussex County 4 years 7 months (each +/- 0.5mth).
2. Sex: Females comprised thirty-seven and one-half percent (37.5%) of the cases reviewed, while males comprised sixty-two and one-half percent (62.5%) of cases reviewed.
3. Race: Fifty percent (50%) of children entering foster care were Black/African-American and forty-five percent (45%) were White. Of the five percent (5%) of remaining children who entered care, half of these (2.5%) were Asian and half (2.5%) categorized as both Black/African-American and White.
4. Language: Seven and one-half percent (7.5%) of children were noted to have a primary language other than English (all were Spanish-speaking).
5. Ethnicity: Eighty-seven and one-half percent (87.5%) of children who entered care were categorized as non-Hispanic and twelve and one-half percent (12.5%) as Hispanic.
6. Site of first placement upon entering foster care: More than half of first site of placements (55%) were into DFS foster homes. About one fifth of children (22.5%) entering foster care were placed first into a contract foster home. Fifteen (15%) percent of children were first placed with a relative, while five percent (5%) were first placed in a shelter and two and one-half percent (2.5%) into a group home.
7. Average number of placements per child (including respite): 6.28 placements
 - a. Least number of placements: 1
 - b. Most number of placements: 16
8. Reason for entry into foster care: physical abuse (17.5%), sexual abuse (7.5%), emotional abuse (7.5%), neglect (52.5%), dependency (40%), abandonment (2.5%) and other (5%). **[Please note: Some entrants have more than one reason.]**
 - a. 50% of children have more than 1 reason for entry

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- b. 10% of children have 3 reasons for entry
9. At least 1 (one) identifiable health problem on entry into foster care:
 - a. Eighty-two and one-half percent (82.5%) of entrants had at least one identifiable medical problem
 - b. Seventy percent (70%) of entrants had 2 (two) or more identifiable medical problems
10. Average time from entry until contact with PCP documented: 51 days
 - a. Shortest length of time: Same day
 - b. Longest length of time: 12 months
11. Average time from entry until first health evaluation: 16.8 weeks (unable to be determined from documentation in 9 cases)
 - a. Shortest length of time: 1 day from entry
 - b. Longest length of time: 17 months from entry
12. Average time from entry until first dental evaluation: 10.3 months (out of 22 cases)
[Please note: No information on first dental evaluation could be found in 12 cases. Dental evaluations were considered not applicable for 4 cases for children under the age of 1 year. Dental evaluations for 2 cases were also considered not applicable for children under the age of 3 years, though being over the age of 1 year, dental referral would be applicable at this time].
 - a. Shortest length of time: 1 month
 - b. Longest length of time: 30 months
13. Most commonly documented medical condition at foster care entry (Number of children and teens):
 - a. Asthma (10)
 - b. Environmental Allergies and/or Allergic Rhinitis (10)
 - c. Developmental Delay (6)
 - d. Enuresis and/or Encopresis (5) (inability to control bladder or bowel function at developmentally appropriate age)
14. Most commonly documented Mental Health Condition at foster care entry (Number of children and teens):
 - a. Attention Deficit Hyperactivity Disorder (15)
 - b. Mood and/or Conduct Disorder (7)
 - c. Depression (4)
 - d. Adjustment Disorder (4)
 - e. Substance Abuse Disorder (3)
15. Most commonly documented prescribed medications at foster care entry (Number of children and teens):
 - a. Albuterol (8)
 - Most commonly prescribed for: Asthma, Reactive Airway Disease, Bronchospasm, Wheezing
 - b. Adderall (5) [Brand name for dextroamphetamine and amphetamine]
 - Most commonly prescribed for: Attention Deficit/Hyperactivity Disorder, Narcolepsy
 - c. Focalin (3) [Brand name for dexamethylphenidate]
 - Most commonly prescribed for: Attention Deficit/Hyperactivity Disorder
 - d. Risperdal (3) [Brand name for risperidone]
 - Most commonly prescribed for: Autism, Schizophrenia, Bipolar Mania
 - e. Clonidine (3)
 - f. Most commonly prescribed for: Attention Deficit/Hyperactivity Disorder, Hypertension

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16. Percent of entrants on medications at foster care entry (Number of children and teens): 62.5% (25)
 - a. Fewest number of medications (of those on medications): 1
 - b. Most number of medications: 5
 - c. Percent of children on only 1 (one) medication at foster care entry: 52% (13)
 - d. Percent of children on 3 or > medications at foster care entry: 40% (10)
17. Percent of entrants with need for durable medical equipment at foster care entry: 32.5% (13)
 - Most commonly needed equipment: Nebulizer Machine (6), Spacer (4)
18. Percentage of time entrant's PCIC II (first foster care entry) not completed within 5 working days: 67.5% (27)
19. Percentage of time entrant's PCIC II did not include medical and/or mental health information: 30% (12)
20. Percentage of time at foster care entry which presence or absence of allergy not documented: 72.5% (29)
21. Number of cases in which a Medical Subspecialist or Mental Health Practitioner was mistaken for child's Primary Care Provider (2) or medical information obtained solely from parents or foster parents (2): 4

Joint Medical Foster Care Committee Recommendations

1. Support the collaborative efforts of duPont Hospital for Children and Division of Family Services in providing all children entering foster care in New Castle County with a comprehensive health evaluation within 3-4 days of entry.
 - a. Additional support (e.g. transportation) may be needed for foster families living outside of New Castle County, specifically in Kent County, in order to support compliance with this comprehensive intake service.
 - b. No comparable comprehensive medical intake facility exists in Sussex County for children entering foster care. Coordinated and collaborative support must be provided for a facility to offer this service in Sussex County and possibly lower Kent County.
 - c. In order to enumerate and improve understanding of the number and types of incoming cases for which comprehensive intakes are not being completed, a state-wide and time-limited study should be completed for a 4-8 week period.
 - d. To ensure process accountability, precision and accuracy, consideration for a quarterly review of a random sample of intake cases could be evaluated for intake time compared to time of comprehensive evaluation completion.
2. Educational opportunities for Delaware medical providers caring for children in foster care have been identified regarding these children's special health care needs and their increased risk for chronic physical, developmental, behavioral and emotional conditions. An educational activity could be developed to address this gap in community knowledge and practice. This education could include information from the American Academy of Pediatrics Healthy Foster Care America.
 - a. Fundamental principles and standards for health care for children and teens in foster care have been published and established by the American Academy of Pediatrics (AAP) and Child Welfare League of America (CWLA).

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- b. Health screening visit within 72 hours of placement, comprehensive health evaluation visit within 30 days of placement, and follow-up health visit within 60 to 90 days of placement.
 - c. Within 30 days of placement, children and teens in foster care should have the following detailed, comprehensive evaluations:
 - i. A mental health evaluation;
 - ii. A developmental health evaluation if under age 6 years;
 - iii. An educational evaluation if over age 5 years; and
 - iv. A dental evaluation.
 - d. Due to a high prevalence of health care problems and multiple transitions that can adversely impact their health and well-being, children and teens in foster care should have an enhanced health care schedule:
 - i. To monitor signs and symptoms of abuse or neglect, to monitor a child's or teen's adjustment to foster care and visitation, to ensure a child or teen has all necessary referrals, medical equipment, and medications, and to support and educate parents (foster and birth) and kin.
 - ii. Monthly for infants from birth to age 6 months, every 3 months for children age 6 to 24 months, and twice a year for children and teens between 24 months and 21 years of age.
 - e. Initial comprehensive health evaluations will be primarily conducted as part of the intake process at duPont Hospital for Children (in Northern Delaware). All health care providers should be made aware of the process, the importance that these evaluations are conducted in a timely manner, and that information is shared among all the professionals and parents or caretakers caring for the child or teen. Information from these assessments should be shared with child welfare professionals and the courts to ensure that it is incorporated into permanency planning for the child or teen.
 - f. Additional topics of interest and importance to medical providers caring for children in foster care could include billing and coding issues, supporting biological and foster parents, privacy issues, and coping with trauma. A dashboard of screenings completed on and referral services available to foster children and teens could be made available to health care providers caring for these at-risk children and teens.
3. CPAC/CDNDSC applauds the developmental and mental health screening processes occurring as part of the foster care entry process through the Division of Family Services' Office of Evidence Based Practice.
- a. If a screening results in the referral of a child for further evaluation, a structured communication and documentation system should be in place to assure that this information is shared among the primary medical provider and parents (biological and foster) caring for the child or teen.
 - b. Often, both developmental and mental health evaluations (after referral) include questions about development history, family history and other historical data. Complete medical records, biological parents' histories and knowledge of the child, and previous caretaker's observations are usually valuable data to provide clinicians. Assessment of a child or teen presenting with a developmental and/or mental

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health issue requires these records and histories in order to provide the most accurate diagnosis and appropriate treatment path possible.

- c. During the Case Review, there were no fewer than seven (7) instances in which a subspecialist examining a child in foster care documented the need for more historical detail. The information needed was past records, developmental and family history from the biological parent(s), and current caretaker knowledge and observations in order to begin to most accurately establish a diagnosis or recommend a treatment path.
4. Unless parental rights have been terminated for a child in foster care, the biological parents maintain the right to consent to medical treatment and to remain informed about their child's condition and wherever possible, participate in any medical decision-making. Per Title 13 Section 2521(2) of the Delaware Code, DFS is statutorily granted certain powers and duties for children in foster care, which can include consenting to medical care, medical examinations, medical procedures and mental health treatment (except in-patient psychiatric treatment and a few other specific conditions). Foster parents are unable to consent to medical or mental health visits, medical procedures, or vaccinations, e.g. on behalf of the child in their care.
 - a. There were multiple occurrences in the review noted in which the foster parents or relatives of the foster parents signed consent for medical care, medical examinations, medical procedures and/or mental health treatment of a child.
 - b. Due to frequent difficulty with contacting biological parents and/or DFS at the time of service for routine medical care, DFS should consider a phone extension off the main hotline number solely for the purpose of consent of medical treatment. Another option to assure appropriate and timely treatment for children in foster care is a time- and care-limited consent form signed by the biological parents to approve medical treatment while children are in care.
 - c. If the biological parents cannot be reached for consent, termination of parental rights have not occurred, and consent by DFS is the only item needed to approve treatment (e.g. flu vaccine) for a child, this process should be done in an expeditious manner as possible (with DFS having as much medical information as possible to make a safe and appropriate decision). A system which documents the consents and approvals DFS makes on the behalf of parents for an individual child in foster care should be in place and communicated to biological parents as appropriate.
 - d. Improved collaboration and communication between Division of Family Services, foster parents and primary care providers (PCPs) is likely to provide improved health care and well-being of children and teens in foster care.
 - i. During the review, multiple occurrences were documented in which children were seen by PCPs who were without the child's medical records.
 - ii. To assist in communicating pertinent information and records, a caseworker's presence with a foster parent at the PCP's office visit could be highly beneficial.
 - iii. Collaboration and communication with the PCP regarding comprehensive evaluations completed (Mental health, Developmental if under age 6 years, Educational if over 5 years and Dental) could be accomplished at this visit and a plan of care established, thus supporting the role of the PCP as the child's medical home.

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- iv. Review of the appropriate consent process, contact information for biological parents (if applicable) and contact information for caseworker could also be included.
5. Care and diligence must be taken in determining a child's or teen's primary care provider (PCP), especially on entrance into foster care.
 - a. Several instances were noted during the Case Review in which specialist physicians such as pediatric endocrinologists and/or pediatric psychiatrists were documented in FACTS as the child's or teen's PCP.
 - b. Several instances were noted during the Case Review in which PCP records were not attained and/or PCP contact was not made in a timely fashion. At least 7 (seven) occurrences of delayed and/or interrupted health care of the child or teen were found that directly resulted from lack of PCP records on entry.
 - c. Children or teens with chronic physical and/or mental health issues should have a PCP who provides health maintenance services and is the coordinator of all care from specialists. This is especially important in children and teens in foster care as they experience a high frequency of co-morbidities, both psychological and medical.
 - d. If the child or teen was not previously seeing a PCP, the child was missing health maintenance visits, age-appropriate screening and vaccinations, and growth and development may not have been monitored closely.
 - e. If the child or teen was previously seeing a PCP and that PCP was not contacted on foster care entry, potential sources of useful information such as detailed social and developmental history as well as family and psychological history was not obtained.
 - f. The American Academy of Pediatric supports care coordination within a medical home for children with special health care needs. Children and teens in foster care qualify as such.
 6. The Case Review demonstrated that the Transfer Instruction Sheet (TIS) was rarely completed as Delaware's children and teens in foster care were moved from one residence or site to another, either short-term or long-term.
 - a. The TIS has the potential to provide thorough, accurate, and up-to-date information to the child's or teen's immediate caretaker as well as document the transfer of medications (some of which are controlled-substances) and medical equipment. The TIS could include such items as primary care provider's (PCP) name and contact number, upcoming and past appointments, medical and mental health diagnoses, medication and number of pills left, and with whom the child or teen should avoid contact.
 - b. The addition of several important pieces of information should be considered.
 - i. The addition of allergies to medication, food, and environmental exposures and the possible reaction to each is suggested.
 - ii. The addition of durable medical equipment transferred is suggested.
 - iii. The addition of a section on mental health provider, psychologist, and/or counselor is suggested. (Significant number of children on entry have mental health diagnoses and a significant number develop mental health issues while in care.)

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- iv. The addition of dental provider, phone number, last dental visit and next appointment should be considered. Dental emergencies do arise and care at the office where the child or teen may be known should be considered first.
 - c. The deletion of several items on the TIS may not cause any difficulties as these items were noted to be rarely if ever completed in the Case Review, do not seem particularly relevant and may provide space to place other information.
 - i. Removal of “Diagnosed by” in both the Medical Diagnoses and Psychiatric/Behavioral Diagnoses – this is often not known and relevance is only sometimes significant.
 - ii. Combining “Health Care Provider – Phone – Last Appointment” with “Last medical/hospital visit date – Phone number – Where – Reason” into (Primary Care Provider – Phone Number – Last Appointment Date and Reason – Next Appointment)
 - d. Foster care staff and foster parents should be educated on the use of and the expectation of the TIS. Consideration should be given to a TIS Performance and Compliance Monitoring Plan.
- 7. A child or teen entering foster care should have an accurate documentation of allergies to medications, foods, and/or environmental exposures easily accessible. Children or teens themselves may not know which allergies they suffer from or what type of reactions they have with which substances. Undergoing medical treatment whether from vaccine administration, sutures from a dog bite, to routine dental care, can expose a child or teen to substances which may induce a life-threatening allergic reaction.
 - a. Consideration should be given to attaining a Medic-Alert bracelet for children and teens with severe allergic reactions.
 - b. Allergies to medications, foods, dyes, and environmental stimuli should be documented and on the child’s and teen’s TIS.
 - c. It was noted several times during the Case Review that case workers accompanying children or teens for a medical or dental treatment had no knowledge of the allergies of those children and teens.
- 8. In accordance with and as recommended by American Academy of Pediatric Dentistry (AAPD), children and teens entering foster care should quickly establish a dental home and an Oral Health Policy for children and teens in foster care should be established.
 - a. As supported by the American Academy of Pediatrics, American Dental Association, American Academy of Pediatric Dentistry and supporting organizations of Bright Futures, the first clinical oral examination should occur by the age of one (1) year. Dental caries and its sequelae are among the most prevalent health problems facing infants, children and adolescents in America. Caries in primary dentition is highly predictive of caries occurring in permanent dentition. Education, early intervention, and prophylactic services are critical.
 - b. Most common interval of examination is six (6) months however some patients may require examination and preventive services at more frequent intervals.
 - c. If living in a rural area of Delaware, the foster home’s water source (e.g. well water) should be known, as a possible need for fluoride supplementation exists. (If the

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- foster family does not take child or teen to the health care visit or dental exam, this information may not be available.)
- d. Frequently noted during the Case Review was the documented need for yearly dental visits in children and teens, which is not standard.
9. DFS requires the completion of the Plan for Child in Care (PCIC) series for every child or teen that enters foster care. In the Case Review, the PCIC II and III had numerous completion failures by deadline, failures in completion and accuracy and failures in attaining required signatures for agreement to plan.
- a. The medical information included in the PCIC II was notably lacking, especially for children and teens with known and identified medical issues on foster care entry.
 - b. The medical information included in the PCIC III was also frequently lacking, incomplete, and without a clear path forward.
 - c. The medical information included in the PCIC II, III and IV was inconsistent and often age-inappropriate. For example, the question regarding occurrence of a physical examination of the child in the last six (6) months is not appropriate for all age groups. For an infant of eight (8) months, it would be very significant if the infant had not been seen at least twice in that time frame. However, in an older child of 8 years, that may not be as significant. Information collection at foster care entry did not differentiate children based on age, developmental or health risks.
 - d. Note that the PCIC will be replaced with the Family Strengths and Needs Assessment as a result of the implementation of the Structured Decision Making® System in Treatment.
10. CPAC/CDNDSC supports the efforts of DFS in its effort to monitor use of psychotropic medications of children and teens in foster care. DFS currently works with the Division of Medicaid and Medical Assistance (DMMA) on this issue by running Utilization Review Reports that monitor use of psychotropic medications.
- a. The reports can be used to outreach to prescribers to educate about medication protocols, collaborate about treatment plans, and identify needs.
 - b. Additionally, a small team is providing screening assessments of all children and youth entering foster care, developing recommendations, and helping to coordinate services.
 - c. CPAC/CDNDSC supports the expansion of this partnership to include insurance claims data review in order to ensure delivery of necessary primary care services, monitoring and compliance with chronic care medications, while at the same time preventing duplication of services.
11. The primary goals for children and teens in foster care include safety, permanency, health and well-being. As evidenced by this Case Review which was a small snapshot, most are entering with chronic physical and mental health issues, on medications and with various needs that are specialized and child-specific. The Committee and DFS recognize a need in the regional offices for medical management to review health records, provide consultation and case management, especially at foster care intake of the individual child.
- a. There may be a training opportunity for student nurses at each DFS Regional Office.

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- b. Consideration for a rotation for Pediatric or Family Medicine and/or medical student rotation should be given, with appropriate supervision.
- c. Due to the inability of multiple medical systems, even within our small state, to easily communicate and the lack of a universal electronic medical record or universal medical passport, a medical or health care manager should be considered for the Division.

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